Once More For Children

The Report of the Province-Wide Study
of Psychiatric Mental Health and Related Services for
Children and Adolescents

Nova Scotia, 1983

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TABLE OF CONTENTS

Acknowledgements
Preface
List of Figures
List of Tables

I Introduction and Summary
II Introduction to Problems in the Provision of Services
III Prevention and Policy Guidelines
IV What We Are Doing Now: Statistics
V Administrative Reorganization
VI The Youth Health Centre Model
VII Priorities
VIII Special Problems of the Metro Area
IX Special Facilities
X Booms, Busts, Suicide
XI Education and Training
XII Conclusions and Research

Appendix i: Terms of Reference of the Study
Appendix ii: Recommendations excerpted from One Million Children
Appendix iii: Methodology, Social Indicators, and the Assessment of Needs

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PREFACE

A mental health professional might have been accused of being part of the problem, given the extent of professional rivalries in the children's/adolescents' mental health field: so an outsider was selected as Principal Investigator, a fieldworking anthropologist, Jerome H. Barkow, Ph.D., Professor of Sociology and Social Anthropology, Dalhousie University.

Outsiders may be objective but there is no doubt as to their ignorance: the Study required and therefore acquired a Senior Advisor: Felton Earls, M.D., at the inception of the Study Assistant in Psychiatry at the Children's Hospital Medical Centre in Boston, later Director of the William Greenleaf Eliot Division of Child Psychiatry and Associate Professor of Psychiatry at Washington University, St. Louis.

Advisory Committee

The Metropolitan Mental Health Planning Board administered the Study but, since the report was to be province-wide in scope, an Advisory Committee representative of the broad field of children's/adolescents' services was needed. The Association of Mental Health Staffs of Nova Scotia was asked to provide three members of the Advisory Committee, and the various other organizations listed below each provided an additional member. These were:

Association of Mental Health Staffs of Nova Scotia. Represented by:

(1) Douglas Archibald, M.D., F.R.C.P., Community Psychiatrist, Fundy Mental Health Centre, Wolfville. (2) Andrew Arsenault, M.S.W., Social Worker, Cape Breton Hospital, Sydney. (3) Elizabeth E. Douma, M.S.W., Director of Social Services, Dawson Memorial Hospital, Bridgewater; replaced in 1982 by L.R. Denton, Ph.D., Psychologist, Atlantic Behavioural Science Applications, Truro.

Children's/Adolescents' Committee, Metropolitan Mental Health Planning Board. Represented by Gerald Gordon, Ph.D., Executive Director, Atlantic Child Guidance Centre, Halifax-Dartmouth-Sackville. Chairman of Advisory Committee.

Department of Education, Province of Nova Scotia. Represented by Donald Feron, M.Ed., Guidance Consultant.

Department of Health, Province of Nova Scotia. Represented by Ralph Townsend, M.D., F.R.C.P., Administrator, Psychiatric Mental Health Services.

Department of Psychiatry, Dalhousie University. Represented by Benjamin Doane, M.D., F.R.C.P., Professor and Chairman. Replaced in 1981 by Herbert Orlik, M.D., F.R.C.P., Associate Professor; and Department of Psychiatry (Children's), Izaak Walton Killam Hospital.

Department of Social Services, Province of Nova Scotia. Represented by William D. Greatorex, M.S.W., Administrator, Family and Children's Services.

Family and Child Welfare Association of Nova Scotia. Represented by Trevor Townsend, M.S.W., initially Supervisor, Sackville District Office, Department of Social Services; subsequently Director of Family and Children's Services, Department of Social Services. Replaced in 1981 by Robert Butler, B.A., Executive Director, Family and Child Welfare Association of Nova Scotia.

The Advisory Committee also included Senior Advisor Dr. F. Earls, as well as:

John P. Martin, D.H.A., Executive Director, Metropolitan Mental Health Planning Board, Halifax, who served as Secretary.

Louis E. Moir, Judge of the Family Court, who served as Honorary Chairman.

Alexander H. Leighton, M.D., Professor of Preventive Medicine and of Psychiatry, Dalhousie University.

Advisory Committees and Principal Investigators are not immune to the problems of "group-think" discussed in chapter II: an outside sociologist consultant, one who did not meet regularly with the Advisory Committee but who was familiar with the problems of young people, was an asset: Professor Robert C. Kaill, of the Department of Sociology and Social Anthropology, Dalhousie University.

The Study was very much a collaborative effort, with the Advisory Committee discussing working papers and draft chapters in some detail. The Principal Investigator did the research and the writing, and it is he alone who must bear responsibility for the undoubtedly present imperfections of the final draft; but the contributions of the Advisory Committee, Senior Advisor, and consultant were very great.

The Study's inception was a letter to the Metropolitan Mental Health Planning Board from the Honourable Gerald Sheehy, Minister of Health of Nova Scotia, dated January 12, 1979. An advisory committee was formed, the terms of reference and budget established, and a search committee created to recruit a principal investigator and senior advisor. The actual Study got underway in April, 1981. It concluded in March, 1983.

LIST OF FIGURES

1. Percentage of Each County's Share of the 0-9 and 10-19 Age Groups in 1981 / IV-9.

2. Number of Mental Health Outpatients for Nova Scotia (1981) / IV-20.

3. Mental Health Outpatients per Thousand Population by Age and Sex for Nova Scotia, 1981 / IV-21.

4. Comparison of Number of Mental Health Outpatients per Thousand Population for Nova Scotia (1981) and Saskatchewan (1978) / IV-24.

5. Scattergram Comparison of County Rank for Age 0-19 Outpatient Mental Health Facility Utilization Rates versus M.S.I. Mental Disorder Diagnosis Rates / IV-179.

6. Number of Age 0-19 Mental Health Facility Patients Compared with M.S.I. Mental Disorder Patients, per Thousand Population, by Age Group and Sex, Nova Scotia, 1981 / IV-184.

LIST OF TABLES

1. Nova Scotia's Population by Age and Sex, by County, 1981 / IV-7.

2. Ranking of Counties by their Percentage of the Provincial 0-19 Age Population for 1971, 1976, and 1981 / IV-10.

3. Population Figures and Percentages by Age Group for Nova Scotia, 1971, 1976, and 1981 / IV-12.

4. Number of Age 0-19 Psychiatric Outpatients per Thousand Population for 1976 and 1981, for Nova Scotia / IV-14.

5. Outpatients per Thousand Population, by Age Group and Sex, for each County, 1981 / IV-16.

6. Mental Health Outpatients per Thousand Population by Age Group and Sex for Nova Scotia (1981) and Saskatchewan (1978) / IV-23.

7. Comparison of Representation of Age Groups in General Population with their Representation in Outpatient Population, for Nova Scotia, 1981 / IV-25.

8. Expected and Actual Age Distribution of Mental Health Outpatient Registrations, for each County, 1981 / IV-27.

9. Number and Percentage of Outpatients, by Age Group and Sex, for Eleven Mental Health Facilities, 1981 / IV-32.

10. Expected and Actual Age Distribution of Outpatient Registrations for Nine Mental Health Facilities, 1981 / IV-35.

11. Comparison of Staff Involved in Initial Assessment of Outpatients, by Age Group and Sex, for Thirteen Mental Health Facilities, 1981 / IV-38.

12. Comparison of Staff Involved in Outpatient Contact, by Age Group and Sex, for Thirteen Mental Health Facilities, 1981 / IV-53.

13. Total Contact Time and Average Time per Contact by Type of Staff Involved, for Thirteen Outpatient Facilities for the 0-19 Age Group, 1981 / IV-68.

14. Average Contact Time and Number of Contacts per Outpatient for Thirteen Facilities by Age Groups, 1981 / IV-72.

15. Contact Interviewee, by Age Group, for all Outpatient Mental Health Facilities, 1981 / IV-75.

16. Average Number of Staff Involved Per Outpatient Contact, by Age Group, for Thirteen Facilities, 1981 / IV-77.

17. Average Number of Days Between Outpatient Registration and Case Closure, for Eleven Mental Health Facilities, 1981 / IV-81.

18. Location of Outpatient Contact, by Age Group and Facility, for 1981 / IV-85.

19. Average Total Staff Time per Patient, by Age Group and Latest Diagnosis, for all Age 0-19 Psychiatric Outpatients, 1981 / IV-89.

20. Type of Treatment, by Age Group and Sex, for Thirteen Outpatient Mental Health Facilties, 1981 / IV-94.

21. Percentage of Outpatients Previously Treated, by Facility and Age Group, 1980 / IV-109.

22. Reason for Referral, by Age Group and Sex, for Six Outpatient Mental Health Facilities, 1981 / IV-110.

23. Diagnostic Impression of Outpatients, by Age Group and Facility, 1981 / IV-118.

24. Primary Diagnosis, by Age Group and Facility, for all Psychiatric Inpatient Admissions, 1981 / IV-151.

25. Area and Degree of Impairment for Psychiatric Inpatient Admissions of the 0-19 Age Group, for Four Hospitals, 1981 / IV-159.

26. Family History of Psychiatric Disorders by Age Group, for Four Psychiatric Inpatient Hospitals, 1981 / IV-162.

27. Length of Stay for Psychiatric Inpatients, by Age Group, for Five Hospitals, 1981 / IV-163.

28. Treatment Services by Age Group for each Psychiatric Inpatient Hospital, 1981 / IV-166.

29. All Psychiatric Diagnoses by Percentage and per Thousand Population, by Age Group for Nova Scotia, 1981 / IV-168.

30. Proportion of Nova Scotia Population Treated at Mental Health Facilities in 1981 / IV-173.

31. Total Nova Scotia Inpatients and Outpatients by Age Group and Sex, 1981 / IV-174.

32. Rate per Thousand Comparison of Age 0-19 M.S.I. Mental Disorder Patients versus Mental Health Outpatients, by County, 1981 / IV-177.

33. Number of Age 0-19 M.S.I. Mental Disorder Outpatients (Categories 291-319) for Fiscal 1981, by Age and Sex Category, for each County / IV-180.

34. Comparison of Proportion of Age 0-19 Population Treated at Mental Health Facilities with Proportion Treated by Private Practitioners, 1981 / IV-186.

35. Proportion of Private Practitioners' and Isaak Walton Killam Hospital Patients with Diagnosed Mental Disorder by Age and Sex for Fiscal 1981 / IV-188.

36. Percentage of Private Practice Patient Population and Total M.S.I. Expenditure Contributed by Mental Disorder Patients, by Age Group and Sex, for Nova Scotia, 1981 / IV-190.

37. Amount and Percentage of Total M.S.I. Funds Paid to Private Practitioners on a Fee for Service Basis for Mental Disorder Patients in Fiscal 1981 by Age Group and Sex / IV-192.

38. Number and Percentage of Mental Disorder Diagnoses for which Private and Isaak Walton Killam Hospital Practitioners Received Payment from M.S.I. on a Fee for Service Basis, in Fiscal 1981, by Age, Sex and Diagnostic Category / IV-193.

39. Amount and Percentage of M.S.I. Funds Paid to Physicians on a Fee for Service Basis During Fiscal 1981, for Mental Disorders, by Age Group and Sex / IV-198.

40. Admitting Policies for Mental Health Programs for Children/Adolescents Located in the Halifax-Dartmouth Metropolitan Area and Financed by the Department of Health of Nova Scotia / VIII-18.

41. Suicide Rates per 100,000 Population, by Age Group and Sex, for the Maritime Provinces and Canada, 1979, 1980 / X-4.

42. Suicide Rates in the 0-20 Age Group, by Sex, for Each County, 1980, 1981, 1982 / X-5.

43. Ranking of Counties According to Six Social Indicators and Each County's per Thousand 0-19 Population / Appendix iii-4.

Chapter I

INTRODUCTION AND SUMMARY

Was there any need for this Study? The early literature review and interviewing quickly revealed that what parents and professionals were saying today repeated what earlier studies had found. The more than a decade old, Canada-wide study of learning and emotionally disturbed young people, One Million Children, was, unfortunately, not at all out-of date.[1] Nor was there anything unique about Nova Scotia's problems.

But why had not the wise recommendations of past studies been implemented? Why were we still giving our children so much less than they need and deserve? The focus of the Study shifted to trying to answer this question, and the resulting conclusions are presented in chapter II. These answers, though, begged another question: how do we organize services in such a way as to build structures and processes that will cope with the recurring problems found, each time they arise. Processes, for example, that ensure that local communities order their priorities instead of simply demanding more of all needed services. Processes that ensure that staffing and range-of-skill decisions be made on the basis of scientific knowledge rather than personal predilection. Processes that limit professional rivalries. Structures that ensure that child and adult will no longer have to compete for services (a competition which the child almost always loses, in Nova Scotia).

Summarizing Main Points and Recommendations

What follows is a triple summary, a summary of the summaries found at the end of each chapter. It is to the actual Report as the smell of cooking is to the eating. The summary of Chapter II is omitted. Chapter II is already a summary.

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[1] An edited version of One Million Children's recommendations constitutes appendix ii.

I. Administrative Reorganization (based on Chapter V)

This set of recommendations is addressed specifically to the Minister of Health and his cabinet colleagues. The first half of this set, IA, is given the highest priority of all recommendations made in Once More For Children. It will be very difficult to implement other recommendations if IA is not acted on first.

A. Rather than a new Department of Children's and Adolescents' Services, a cabinet-level Youth Secretariat is recommended, working in conjunction with Local Committees.

1. The Secretariat would consist of the Ministers of Health, Education and Social Services; of their deputies; and of an appropriate senior administrator from each Department.
2. The Department of Health requires a director or coordinator of psychiatric mental health services for children and adolescents. This individual would serve as a member of the Youth Secretariat.
3. The Secretariat would have a Staff of 3-6, headed by a senior administrator.
4. It would have no programs of its own but would serve to coordinate existing programs affecting services for children and adolescents, facilitate communication and policy planning between the Local Committees and the Secretariat, uphold minimum standards of service, make policy recommendations to the Secretariat and evaluate the appropriateness and effectiveness of existing policies.

B. The Local Committees:

1. would be regional in nature and include social service, educational and mental health professionals, and private individuals, with a general membership of 30-35. In the Metro area, the Metropolitan

Mental Health Planning Board would perform the function of the Local Committee.

2. would be charged with general planning of children's/adolescents' services for their respective regions. They would meet 2-3 times each year.
3. would have a working executive of perhaps eight individuals who would meet on a monthly basis.
4. and the Secretariat Staff would be expected to analyze, endorse or reject any proposal affecting children's and adolescents' services in a particular locality.

C. Secretariat Staff would meet regularly with Local Committees, providing a wider perspective, mediating disputes, and advising. Staff would have only a strictly limited power over Local Committees (e.g., arbitrating boundary disputes among Local Committees). The influence of Staff would flow in large measure from its expertise, familiarity with research findings; and from its function of advising the Secretariat on programs, budgets, and priorities with respect to services for children and adolescents.

D. Final decisions on all programs would remain in the hands of the appropriate cabinet ministers.

E. If financial constraints so required, the Secretariat Staff could consist of individuals seconded from existing programs. (The Local Committees would not in any case require additional funding). Thus, depending on the manner in which it was implemented, the proposed Youth Secretariat/Local Committees model could be implemented at relatively little cost.

F. If a review study four years after the inception of the Youth Secretariat/ Local Committee model found that major problems in the provision of services for children and adolescents remained, then a Task Force should be appointed to put all or most such services under a single administrative unit.

II. The Youth Health Centre Model (based on Chapter VI)

This set of recommendations is addressed specifically to the Minister of Health and, more generally, to the Youth Secretariat and its Staff.

A. The Youth Health Centre (YHC) model refers to a flexible range of ways of organizing the delivery of mental and other health services to children and adults.

1. The YHC model does not apply to the Halifax-Dartmouth metropolitan area, for which a separate set of recommendations will be made.

B. Guiding principles.

1. Mental heath facilities for young people must be kept physically, budgetarily and programmatically as separate as possible from those for adults. Stigma is part of the reason for this guideline, competition the other.
2. There must be no competition between mental health services for adults and those for children and adolescents. Competition here means budgetary competition, competition in terms of range of services to be available, and competition for staff time and appointments. In Nova Scotia, wherever these kinds of competition have been permitted to occur the young have been the losers.
3. Mental health services for young people should be combined, wherever possible, with general health services.

C. Organizing Youth Health Centres.

1. A portion of the psychiatric services budget of each non-Metro mental health facility must be dedicated to the 0-19 age group and made non-portable. That portion should initially reflect the proportion of a

facility's outpatient efforts currently devoted to young people (as indicated by tables 9, 10 and 14 in chapter IV) and will be referred to as the "youth services budget".

2. A minimum YHC will be a clinic of an existing non-Metro mental health facility staffed by whichever current personnel have the most expertise in the problems of young people. It will provide a major portion of its services in settings physically distinct from the adult mental health agency. It will be financed by the youth services budget.
3. A maximum YHC is a facility physically and programmatically separate from an adult mental health service and staffed by child psychiatrists, psychologists, social workers, pediatricians, and other health and mental health personnel (such as speech therapists, occupational therapists, nurses, etc.). It should have its own advisory committee. It may include under its auspices related facilities and programs such as therapeutic group homes, day care and residential treatment centres.
4. As a short-term goal, minimum YHCs should be created wherever there are existing mental health facilities. Since these will utilize current personnel and borrowed physical facilities, they can be organized immediately and at little cost.
5. As a medium-term goal, at least one or two maximum YHCs should be created as pilot projects.
6. As a long-term goal, there should be a maximum YHC in every part of the Province. To the extent that budget and staff shortages make it feasible, minimum YHCs should gradually be helped to grow into maximum YHCs.
7. The Youth Secretariat Staff is to play a major role in the initial organization and continuing encouragement of YHCs. (Aiding in recruitment of staff and organizing tours of traveling experts to relieve staff shortages are two ways in which it may do this.)
8. A YHC must retain close links with its parent mental health facility by, for example, cross-appointed staff members and regular meetings.

Separating mental health facilities for young people from those for adults is meant as a means of increasing services to them rather than as an end in itself. Separation must not be carried to the point at which it is no longer possible to treat a family as a unit.

9. The YHCs must cooperate with other helping agencies in identifying and closing gaps in the network of services for young people. Here, the Local Committee structure and the Secretariat Staff will play a major role.

D. Less Major but Still Important Recommendations.

1. YHC and child welfare staff must either share common coffee facilities or else schedule regular informal meetings to facilitate communication. Similar meetings with appropriate educational and other personnel are also to be encouraged.
2. YHC staff members should be periodically seconded to child welfare agencies and, where possible, educational systems in order to learn first-hand of the needs of their colleagues.
3. At least one member from each YHC is to be trained in the purposes and duties of court clinics in order to provide, to the extent possible, court clinic services to family courts and to special protection (juvenile probation) officers. The court clinic being planned by the Atlantic Child Guidance Centre should provide this training.
4. There must be the closest cooperation between the YHC and social welfare staff in cases of actual or suspected child abuse.
5. Even where a young person has no parents or where the parents are uncooperative, the YHC staff must make every effort to treat children needing their help and not, when these children happen to be wards, simply refer them back to the child welfare worker.
6. Child welfare workers must, in cases of emergency, have immediate access to YHC staff.

7. Social service facilities requiring "back up" mental health services for age 0-19 individuals should be invited to establish a formal agreement with a YHC, which will then be expected to provide routinely both assessment and treatment services.

E. Mandated YHC Responsibilities.

1. Where a young person is being served by more than one facility or agency, the task of coordinating services belongs to the YHC.
2. In order to permit the YHC coordinator to accomplish his or her task free of possible legal restrictions, this Study recommends that a committee, consisting of at least one member from the Department of Health, from the Department of Social Services, from the Department of Education, and from the Department of the Attorney General, be struck to determine whether and how the Hospital's Act and other relevant legislation should be altered to permit more full cooperation among agencies serving young people.
3. Monitoring of children and adolescents in "high risk" categories, along with monitoring of chronic patients, must be a mandated responsibility of the YHC.
4. The community health nurses of the Health Units must have primary responsibility for the regular home visits long-term monitoring requires, and for reporting their findings to the YHC.
5. Therefore: (a) each YHC must have access to basic computer facilities so that a registry of high risk and former patient families can be maintained and regular lists of home visits can be generated in a systematic manner; (b) the number of community nurses may eventually need to be increased, in line with these new duties; (c) and YHC staff and community health nurses and their supervisors and Health Unit directors must be trained together to cooperate in monitoring and other prevention activities.

6. Given that most of the Province will not have maximum YHCs for some time, the Local Committees must address the question of which agency or agencies in each region will be best able to discharge temporarily some of these mandated YHC responsibilities.
7. A YHC must have a staff member on call at all times. All YHC staff members (and not just the physicians) should be compensated for out-of-hours work.
8. YHCs should have regularly scheduled hours during some evenings and weekends.

III. Prevention (based on Chapter III)

The following recommendations are addressed to the Minister of Health, the Youth Secretariat and its Staff, and to the members of the Local Committee.

A. Programs which are worthy ends in themselves should not be portrayed or justified as "mental health" prevention programs (e.g., day care centres, courses on parenting).

B. There must be clear budgetary separation between services for the acutely ill on the one hand and for primary prevention on the other, lest the one prosper at the expense of the other.

C. All primary and secondary prevention programs should be organized as research projects with clearly stipuated goals in order that their effectiveness—and worthiness to be continued and expanded—can be objectively evaluated.

D. Since engaging in "preventive" work appears to help mental health facility staff to avoid "burn out", direct treatment staff should be permitted and even encouraged to work at primary prevention for a maximum of 20 percent of their work time.

E. To the extent that mental health staff engage in preventive activities, they should focus their efforts primarily on children and adolescents (and their families) in high risk groups.

F. We should only screen for problems for which we have treatment programs of proven effectiveness in place.

G. Research into the utilization of Nova Scotia's medical (MSI) and mental health services is likely to have considerable planning and program implications and should be funded by the Department of Health.

IV. Setting Priorities (based on Chapter VII)

These recommendations are intended for the Youth Secretariat Staff, the Local Committees, and the Minister of Health. Recommendations are marked by an asterisk. Other items are for information only.

A. Previous studies emphasized that "more" services were needed, ignoring the setting of priorities and the limits to resources. But more young people could potentially benefit from mental health services than we can ever hope to serve: we must set priorities.

*B. Decisions concerning the range of services to be available at a YHC, as well as the types of clinical expertise required, are to be made in the light of scientific research findings. Such scientific data should involve: (1) epidemiology; (2) the seriousness of the various disorders; (3) the effectiveness of treatment and its costs vs. the likely benefits; (4) what problems are most effectively treated by what kinds of professionals; and (5) whether long-term or short-term treatment is most likely to be cost-effective.

*C. Decisions concerning the high-risk target populations to be combined with the preventive/research efforts previously mentioned are to be made in the light of the scientific literature.

*D. Decisions concerning the budgetary priority of regional programs and facilities (e.g., day care, residential treatment centres) are to be made by the Local Committee with the aid and advice of Youth Secretariat Staff, who will take into account how planned facilities fit into the total network of services.

E. The setting of priorities is a political process and the Local Committee must establish its own consensus, though with the aid and advice of Staff.

V. Conclusions Stemming from Statistical Analysis (based on Chapter IV)

The data from which these conclusions and recommendations arise are contained in chapter IV. All recommendations are specifically intended for the Minister of Health, and for the Secretariat Staff. Recommendations are marked by an asterisk.

A. Despite a drop in the proportion of the population in the 0-19 age range, mental health and related services for children and adolescents must not be decreased, given the apparent inadequacy of services in much of the Province.

B. There are sharp variations from county-to-county in outpatient mental health facility utilization, with Kings County having the high of 15.8 outpatients per thousand population between the ages of 0 to 19, and Victoria County having the low of 2.1 (1981 data). Low utilization counties are not compensating by increased use of private physicians for mental health services.

C. Nova Scotia in 1981 and Saskatchewan in 1978 had the same rate of outpatient mental health facility utilization by children and adolescents.

D. It is relatively rare for a private medical practitioner to refer a child or adolescent mental disorder patient to an outpatient mental health facility, instead providing treatment himself/herself.

*E. There must be centralized training courses for mental health facility staff responsible for filling out routine forms dealing with inpatients and outpatients, in order that the data generated from these forms be valid and reliable.

*F. The Department of Health should create a committee to review its data collection and analysis procedures with respect to psychiatric outpatients. This committee should include at least one professional researcher likely to use the resulting data in program research; one administrator likely to use the resulting data in administering mental health services; and one individual whose daily work requires him/her to fill out these forms. The Committee should begin its work by focusing on the purposes for which data are to be collected.

*G. Mental health staff should be provided with uniform training in the use of psychiatric diagnostic categories. (This recommendation is expanded in chapter XI.) That training should pay special attention to autism.

*H. If mental health facilities (Youth Health Centres) are to cooperate closely with social service agencies then the former must have considerable expertise on staff in the management of young people suffering from conduct disorder.

*I. Secretariat Staff should consider offering some services specifically to young women in middle and late adolescence, since these are receiving mental disorder diagnoses from physicians at nearly three times the rate for young men in the same age category.

VI. Special Problems of the Metro Area (based on Chapter VIII)

These points and recommendations are brought to the attention of the Minister of Health, the Children's/Adolescents' Committee of the MMHPB, the Secretariat Staff, Dalhousie University, and the Izaak Walton Killam Hospital and Nova Scotia Hospital. Recommendations are marked by an asterisk.

A. Many of the problems of the Izaak Walton Killam and Nova Scotia hospitals are caused by the lack of alternative facilities elsewhere in the Province. Chapter VI's and IX's recommendations for increased services and facilities in the non-Metro area should in themselves alleviate many Metro problems.

*B. Metro facilities treating non-Metro patients must collaborate closely with local personnel in developing implementable treatment plans.

*C. Since direct video links would reduce the number of non-Metro patients who must be transported to Metro, YHC Staff should begin planning equipment formats now so that in the future the various Metro and non-Metro mental health facilities do not purchase incompatible equipment.

*D. The Atlantic Child Guidance Centre should be the major source of outpatient mental health services for children and adolescents in the Metro area. Neither the Nova Scotia Hospital nor the Izaak Walton Killam Hospital should ordinarily accept outpatients except when doing so would be required for continuity of care (e.g., a former inpatient requiring outpatient treatment). Since the inpatient and consultative functions of the Izaak Walton Killam Hospital and Nova Scotia Hospital serve the entire Province and beyond and since their outpatient services essentially duplicate the work of the three branches of the Atlantic Child Guidance Centre in providing outpatient services to Metro, the two hospitals should minimize their outpatient roles and emphasize their unique and Province-wide services.

*E. Since training in multidisciplinary settings is believed to reduce the problems of professional rivalry discussed in chapter III, and since the Izaak Walton Killam Hospital will no longer have sufficient mental health outpatients for teaching purposes, the Atlantic Child Guidance Centre should formally arrange with Dalhousie University to accept substantial medical training responsibilities.

*F. The Atlantic Child Guidance Centre in the past suffered from lack of adequate psychiatric staff time. Giving it teaching responsibilities, however, implies that Dalhousie University medical faculty members be on its staff. For these two reasons, the Atlantic Child Guidance Centre should increase psychiatric and other medical (e.g., pediatrician) participation in its planning and operating activities.

*G. Like the YHCs elsewhere, for Metro the Atlantic Child Guidance Centre must be the facility which not only accepts but specializes in treating, on an outpatient basis, young people with inadequately cooperative or absent parents or parent surrogates.

*H. The Atlantic Child Guidance Centre, Izaak Walton Killam Hospital and Nova Scotia Hospital are to cooperate with Secretariat Staff in aiding the creation and functioning of the YHCs in such a manner that both Metro and non-Metro mental health services for children and adolescents form a single, province-wide network.

*I. A Youth Secretariat Staff member should be made a member of the Children's/Adolescents' Committee of the Metropolitan Mental Health Planning Board, and that Committee continue to have responsibility for coordinating mental health and related services for children and adolescents in the Metro area.

1. It is further recommended that the Committee be expanded by the appointment of the director of the Department of Psychology of the Izaak Walton Killam Hospital.

*J. The expanded Children's/Adolescents' Committee should include on its agenda the following items:

1. Expansion of the range of the Atlantic Child Guidance Centre's services and coordination with the Izaak Walton Killam Hospital Department of Psychology.
2. Creation of a Metro-wide "bed availability" system.
3. Creation of a "least inappropriate referral" system so that a referral cannot be refused by all facilities.
4. The development of Metro-area psychiatric emergency services for young people.
5. A means of assigning long-term responsibility for troubled young people.
6. Regular review of all facilities' internal reward systems to ensure that staff members be provided with incentives for inter-agency cooperation.
7. Assigning responsibility for developing special expertise in the problems of the handicapped young, with special attention to the hearing handicapped.

VII. Special Facilities (based on Chapter IX)

These recommendations are intended for the Minister of Health, the Youth Secretariat, the Secretariat Staff, and the Local Committees.

A. Nova Scotia requires at least one province-wide residential treatment centre for the "impossible" or "hard-to-manage" child.

1. It should have a capacity of 30-60 young people.
2. Its operation will require the cooperation of both the Department of Health and the Department of Social Services.
3. The Department of Social Services has in the past considered creating a residential treatment facility perhaps comparable to the one here recommended and it is suggested that the Youth Secretariat Staff urge that Department to resume this planning.

B. The Local Committees, with aid and advice of Youth Secretariat Staff, must order their priorities for regional special facilities for young people. The following list is not intended to be exhaustive:

1. A regional residential treatment facility.
2. A therapeutic group home.
3. A therapeutic foster care program.
4. Day treatment centres.
5. Crisis intervention centres.
6. Respite care for the parents of the handicappped.

VIII. Economic Booms and Busts, Suicide (based on chapter X)

No recommendations are made in this chapter, since its substance reinforces recommendations made elsewhere in this Report.

A. During economic booms, demands for social and mental health services go up sharply.

B. During economic "busts" or recessions/depressions, social and mental health problems are different but the demand for services also rises. (The chief difference is that, unlike during "boomtime", the economic resources to provide the needed services are likely not to be there.

C. The chief bottlenecks to coping with rapid economic change and resulting demand for service are not primarily financial but staff-related. Recommendations dealing with staff shortages and with training facilities and continuing education for staff are therefore doubly important and discussion of economic changes serves only to reinforce these (recommendations in chapters II and XI are therefore doubly important).

D. Child and adolescent suicide may be on the increase in Nova Scotia. The means for coping with it are once again staff-related and reinforce recommendations made elsewhere (chapter XI) dealing with YHC staff and medical community ability to diagnose depression and manage suicidal young people.

IX. Education and Training (based on Chapter XI)

The recommendations in this chapter are intended for the Youth Secretariat and its Staff, the Atlantic Child Guidance Centre, and Dalhousie University.

A. Nova Scotia is not currently training M.A.-level social workers with child and adolescent oriented clinical/counseling skills. The Staff of the Youth Secretariat is asked to discuss the curriculum planning policies of the Maritime School of Social Work with that School's officials and if necessary to make appropriate recommendations to the Secretariat to ensure that the Maritime School of Social Work produces social workers who meet the needs of the Province's mental health, social service, and educational facilities.

B. Shortages of child/adolescent clinical psychologists at the doctoral level can be alleviated by full funding of the clinical psychology program at Dalhousie University. This Study recommends such funding.

C. In order to recruit and retain trained professionals, it is recommended that:

1. there should be wide publicity given to the existing system of bursaries in child psychiatry, social work and psychology, acceptance of which obligate individuals to remain in the Province for a specified period.
2. the sums paid by these bursaries should be increased to and maintained at levels at which they attract students. (Bursaries for fields other than psychiatry at present provide only token amounts.)

3. admissions committees of training programs pay special attention to applicants from parts of the Province badly in need of qualified child/adolescent professional expertise, provided these applicants indicate a desire to return to their home regions to practice.
4. students in psychology, social work and psychiatry as part of their training spend varying periods of time in mental health and social service facilities in non-Metro areas.
5. administrators of mental health and other facilities with responsibilities for children and adolescents strive to attract and retain scarce professionals and diminish their sense of professional isolation by following generous policies with regard to "sabbatical" leave, attendance at professional meetings, and payment for journal subscriptions.

D. The Youth Secretariat Staff is to have responsibility for monitoring and coordinating continuing education courses for mental health, social service, and educational staff who serve children and adolescents. When needed courses are not available, the Secretariat Staff should so advise appropriate institutions.

E. The Atlantic Child Guidance Centre, which now offers a variety of needed courses, should continue to do so.

F. This study specifically recommends the following continuing education courses:

1. for juvenile probation (special protection) officers and Family Court judges, a seminar on when clinical assessment and/or treatment are appropriate and what realistically can be expected of them;
2. for junior levels of staff at both hospital and non-hospital residentail facilities, seminars and training programs in the problems of children and adolescents, in behavior and other forms of therapy, and in case management;
3. for all mental health, social service and educational personnel dealing with children and adolescents, a course in the skills and capa-

bilities of all relevant professions (including those of child psychiatry, pediatrics, neurology, and family medicine; and those of social work, psychometry, psychology, occupational therapy, nursing, special education and guidance counseling.

G. This Study specifically recommends to Dalhousie University's Department of Continuing Medical Education that it offer to family practitioners the following courses:

1. diagnosis and assessment of children's and adolescents' mental disorders, with special reference to depression and autism;
2. the skills of other professionals who work with children and adolescents and when to refer a patient to them.

H. This Study specifically recommends to Dalhousie University that, in view of the fact that it trains most of the professions (listed in F3, above) providing mental health and social services to children and adolescents:

1. it review its curricula for these varied professions in order to include as many joint seminars, courses, and learning experiences in general, with the goal of diminishing future professional rivalries and enhancing future professional cooperation;
2. It specifically includes in these programs full information on the skills and capabilities of allied child/adolescent oriented professionals.

I. The Atlantic Child Guidance Centre and Dalhousie University should enter into a formal arrangement whereby the Atlantic Child Guidance Centre's settings and staff play a substantial role in the training of mental health and related professionals (e.g., physicians, psychologists, social workers, occupational therapists, special education teachers, guidance counselors, nurses, etc.) who will be concerned with the problems of children and adolescents. (The goal here is for experience in the Atlantic Child Guidance Centre's multidisciplinary setting to help minimize future professional rivalries).

X. Research Recommendations (based on Chapter XII)

These points are intended for the Minister of Health and the Youth Secretariat and its Staff. Recommendations are marked by an asterisk.

A. The most dismaying finding of this Study was the extent to which decisions and priorities in mental health services for young people have not been made on the basis of research data.

*B. The Youth Secretariat is charged with ensuring that needed program research and evaluation take place. The Secretariat should follow one or more of the following options:

1. providing grants on a competitive basis to researchers for needed program research and evaluation of services.
2. letting contracts to private firms and individuals for needed program research and evaluation of services.
3. maintaining its own research and evaluation capacity. While maintaining a full research/evaluation capacity is likely to be inefficient unless all age groups and provincial departments are to be served by it, basic research/evaluation capacity is necessary if either of the preceding two options is to be followed.

*C. Multiproblem families remain a major but un-targeted problem in that they frequently are part of the generation-to-generation transmission of social and mental health problems. This Study therefore recommends a multi-department task force be established with the goals of:

1. identifying the pockets of multiproblem families throughout the Province;
2. targeting specific communities as "pilot projects";
3. designing a long-term plan for breaking the generational transmission of problems by concentrating the energies of relevant "helping" agencies on the well-being and welfare of the children.

Chapter II

INTRODUCTION TO PROBLEMS IN THE PROVISION OF SERVICES

Chained to a typewriter, somewhere on this continent, is a single author. It is he or she who produces all the government reports on the problems of young people and the services intended to alleviate them, all the newspaper accounts of the difficulties faced by children and adolescents. The author changes the place names but not the situations described.

The problems of Nova Scotia's young people are not unique. That is the point of the preceding hyperbole. But it is not just that everywhere we hear of learning disabilities and autism, of teenage pregnancy and juvenile delinquency: everywhere we also hear the same accusations against the services provided to relieve these problems, complaints of lack of facilities, lack of coordination among services, fragmentation and rivalries among "helping" professions. Everywhere, too, we see pendulum swings between "moralistic" explanations of young people's problems (the kids are bad, lack discipline, the parents lack discipline, we need more Bible classes, etc.) and social/behavioral science explanations (the family is changing, socioeconomic conditions are bad, the divorce rate is too high, young people lack role models, parents do not know how to "parent", etc.).

Other jurisdictions do not seem to have had any remarkable successes in solving these two sets of problems, that of the young people on the one hand and that of the services provided them on the other.[1] That is one implication of the ubiquity of the problems and accusations mentioned previously. The other implication is that neither the troubles of our children and adolescents nor the troubles we have in ministering to them stem from some special aspect of Nova Scotia's history and heritage or from any special foolishness of our politicians and educators, our social workers and psychiatrists. To seek uniquely Nova Scotian causes of our problems is to err.

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[1] One of the problems is that, in the absence of comparable data on the relative effectiveness of our various interventions, it is very difficult to say not only what works and what does not but who is doing a better job than whom.

This chapter focuses on the "ministering" problems: a focus on the actual problems of our young would be premature, since one of the "ministering" difficulties is that we have no consensus on what the problems of our children are. The point the following discussion will make is that the roots of the problems of our health/social service care delivery system for young people do not lie in the malefactions of soap-opera-like evil-doers but in the mindless workings of the social processes analyzed by the social scientist, processes involving the reward systems of bureaucratic structures and the nature of professional rivalries, for example, or the changing nature of the family and its responsibilities vis-à-vis government. Such analyses are dull stuff compared to the emotionally satisfying search for villains but they are a great deal more likely than are witch-hunts to help us help our children. The problems discussed below are recurring, continent-wide problems. Some of them may be salient in Nova Scotia today, some be quiescent; but if they do not trouble us today they can do so tomorrow, so we must remain aware of them. Problems are not presented in order of current seriousness.

Problem 1: Professional Rivalries

Social work, psychiatry and psychology are the three "helping professions" most often involved in the treatment of troubled children and adolescents, along with nursing, occupational therapy, and a scattering of others. But it is the "big three"--psychiatry and psychology in particular--which have the most severe sibling rivalry problems. Their difficulties are comparable to those of inter-service rivalry in the military, or between overlapping academic departments in universities (e.g., sociology and anthropology). Training in a profession is similar to the initiation rituals studied by anthropologists and has a comparable outcome: a new social identity, a strong belief that the insights, skills and perspectives of one's new group membership are uniquely valuable; a sense of loyalty to one's fellow initiates and a distrust of other groups and of their members. These attributes in the context of a mental health unit cause problems.

Many of the professionals currently serving Nova Scotia's young people profess to share an equalitarian philosophy, in some cases arguing that they provide services as a cooperating, multidisciplinary "team". A careful observer, noting (for example) who has the right to interrupt whom in group discussion, might not accept this ideology as descriptive of actual practice.

Part of the problem of professional rivalry reflects the fact that physicians are taught as part of their training--often explicitly--that they are of paramount importance in the treatment of any patient and that other professionals are "ancillary" personnel. Many believe that they retain responsibility for a patient even when virtually all treatment is being provided by another professional. The amalgamation of Nova Scotia's mental health centres with hospitals has reinforced this tendency, since a hospital is almost by definition an institution in which the authority of the physician is indeed paramount.[2]

A psychiatrist who consciously strives to treat other professionals as equals must fight several battles. First, the psychiatrist's own identity as a physician is likely to be bound up with his or her authority over patients, so that yielding authority may well require a change in self-concept. Second, as a professional the psychiatrist is a member of a solidary group, that of other physicians. To the extent that he does not emphasize his uniqueness vis-à-vis other professionals, these may see him as disloyal. For example, a psychiatrist who stresses non-medical, non-drug interventions (e.g, family therapy) may be seen by some other physicians as not being a "real" doctor. Similarly, family practitioners, who are often reluctant to refer to any professional other than another physician, may complain of a psychiatrist who does not treat their referrals directly but instead re-refers them to a social worker or psychologist colleague.

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[2] A fact which makes the profession of hospital administrator a most difficult one.

A third battle "team member" physicians must fight is their own very real belief that their training really does make them the most generalist member of the staff and the only one qualified to decide which other staff members' skills are required by a particular patient. In some instances, as when the psychiatrist has had formal training in community psychiatry, the belief may be justified. In other cases, as when the psychiatrist is unaware of the range of skills a clinical psychologist may have (a not uncommon circumstance among psychiatrists interviewed), the belief is not justified.

A fourth battle has to do with the public, many of whom seek to confer on the physician a priest-like status other professionals lack. It is, after all, wonderfully reassuring in time of trouble to believe that a being just a bit closer to the Deity than the rest of us is helping one. A social worker or psychologist, by comparison, is just another human being.

A fifth battle involves the "but what if the patient really does have a physical illness" problem. Psychiatrists interviewed frequently argued that medical participation in treatment is always a necessity (unlike, for example, social worker participation) because the patient's behavioral problems may be a product of a drug's side-effect or of some other organic condition. Once again, there is some merit in this argument (and in its converse, discussed below).

It is clear, then, that when we expect psychiatrists to cooperate fully and in a spirit of equality with other professionals we are asking a great deal. Why should we not solve the problems simply by assigning to the physician the role of "leader" of the team and paramount authority, in the provision of mental health and related services to young people? Where this is done, two new difficulties arise: The first of these is that many psychiatrists do not, in fact, have the breadth of training necessary for them to make full use of the skills of other professionals. Even worse, where the authority of the psychiatrist is unquestioned, other professionals may not have sufficient input into decision-making (e.g., triage decisions). As in the case of the experienced nurse unable to get the brash young intern to listen to her, high status includes the ability to shut off wise advice from those of lesser status (even if, at times, of more relevant experience or training). Sharp status distinctions in the helping professions can only be viewed as a hazard to the health of patients. But perhaps the most serious negative consequence of assigning the authority role to the psychiatrist is that it may thenceforth become impossible to retain or recruit fully qualified psychologists.

Status rivalry between psychiatrists and clinical psychologists is a special case of the general, North American M.D.-Ph.D. rivalry. In research settings, for example, the Ph.D.s often complain that the M.D.s have comparatively little research training or skills but nevertheless win the larger share of the grants and of any eventual glory. In other settings, some doctorate-holders resolutely insist on being addressed as "doctor",[3] though the style sheet of the New York Times (but not thus far of Canadian newspapers) now reserves the title "doctor" for physicians only.

In the treatment setting, psychiatrist-psychologist rivalry often takes the form of arguments that most behavioral problems are primarily organic as opposed to non-organic ("functional"). (Some psychiatrists and psychologists cross these battle lines, however, reversing positions.) Clinical psychologists frequently maintain that psychiatrists are less well trained than themselves to deal with many functional problems. In reply to the physicians' complaint that psychologists may not recognize organically based problems of behavior, the latter argue that psychiatrists are liable to provide drug or even electro-convulsive therapy to patients actually in need of, say, family therapy. Psychiatrists are quick to acknowledge the psychologists' superiority in certain specialized fields (behavior therapy and psychometrics in particular) but reject any claim to psychological primacy in mental health care.

It is important to note that psychiatrist-psychologist tensions are often mitigated when both professionals have been chiefly trained as pediatric practitioners, or when the psychiatrist has been trained in community psychiatry.

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[3] Historically, it was only quite recently that this title, traditionally an honorific reserved for a scholar, has been applied to physicians, who were of quite low standing until approximately the last quarter of the last century.

The child psychiatrist is much more likely than his generalist equivalent to have been taught to regard the psychologist as a complementing colleague rather than a competitor. Unfortunately, there are few child and community psychiatrists in Nova Scotia and they become especially rare when one leaves the Metro area. Most of the Province's psychiatrists are generalists—that is, adult-oriented—and to some extent this fact results in a paucity of doctoral-level clinical psychologists in Nova Scotia's mental health centres and psychiatry departments. Non-doctorate level psychologists, while much less well trained than their Ph.D. seniors, are much more likely to defer to medical authority rather than to challenge it.

Social workers, nurses, and other professionals are much less likely than the Ph.D. clinical psychologist to engage in rivalry with psychiatrists. Physicians are taught to regard social workers (or at least, medical social workers) with considerable respect and to have some understanding of their role. Moreover, the area of overlap between psychiatry and social work is much less broad than that of psychiatry and psychology, so that competition for supremacy in the mental health field is correspondingly reduced. The training of nurses includes explicit instruction in not just deferring to but in obeying "doctor's orders" so the possibility of conflict in a mental health setting is small.[4]

Where tensions do arise between social workers and the other "helping" professions the problems are likely to arise not so much from conflict over authority as conflict over the role of a mental health unit. Some social workers in Nova Scotia's mental health facilities have had relatively little training in either medical social work or in clinical skills. Rather, they have been trained to regard themselves as agents of community change. Viewing mental health problems as more effectively resolved at the level of the entire community rather than by providing therapy to individuals, their view of the mission of a mental health facility may be quite different from that of many psychologists and psychiatrists.

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[4] Conflict between nursing and the medical professions as a whole is growing, however, as nurses seek to be regarded as professionals in their own right with their own special areas of expertise and control over their own training and standards. A "nurses' lib" movement has been in progress in North America for some years, and has achieved considerable success.

Problem 2: Scope of the Field and of this Study

The scope of this Study, as described in the terms of reference (appendix i), involves "psychiatric mental health and related services" for children and adolescents. As Leighton (1982) has recently discussed, the term "mental health", even standing alone, is a treacherous one. Its meanings range from mental illness, to the absence of mental illness, to functioning at one's full potential to functioning well enough to play one's social roles.

If all this were not sufficiently confusing, prefacing "mental health" with "psychiatric" brings coals to Cape Breton. "Psychiatric" refers to a branch of medicine and deals with treatment of mental illness. "Psychiatric mental health" would appear to mean something like "health through illness." In fact, it means nothing of the sort: it appears to refer to services provided by or at least in part controlled by psychiatrists; in the Nova Scotia context the term refers, of course, to services for which the Administrator of Psychiatric Services is responsible. This last definition did, indeed, set the primary focus of this Study. Focus is not scope, however: in its broadest sense it is difficult to envisage mental health as not being affected by the entire range of government services, including revenue collection. The addition of "related services" underscores the possibility that anything which affects children or adolescents, or their parents, could be included in the Study.

The vagueness of the term "mental health" is mirrored by the ambiguity of the mission of the various "mental health" facilities in Nova Scotia. Should they focus on "prevention" of mental illness? Should they spend their energies helping people who are accutely ill? Or would it be wisest for them to strive to enrich human lives by helping their patients/clients to realize their potential, to self-realize or self-actualize? Perhaps their primary purpose should be to aid people to cope with the ordinary problems of life, bereavements, divorces, and such? Unfortunately, finite resources make it impossible for any facility to do justice to all of these goals (and in some cases, to any of them): in practice, each facility tends to have its own focus, one which presumably reflects the predilections of its more senior staff. Chapters III and II will discuss the question of the goals and priorities of mental health facilities for young people at greater length.

Problem 3: State of the Art and Unrealistic Expectations

There are few fields quite so vulnerable to criticism as that of mental health services for children and adolescents. It is important that we not fall into the trap of blaming Nova Scotia's professionals for the state of their art: they are more the heirs of a confused situation than its creators.

Fundamental unresolved issues include whether the goal of treatment is to maximize human potential or to alleviate illness, whether biological etiologies and interventions are more appropriate for young people's behavior and developmental problems than are non-biological approaches, and even whether the troubled person is to be viewed as a patient receiving treatment or a client being re-educated. There is a clear tendency for psychiatrists to favor a more biological approach than do clinical psychologists, as was discussed previously, though it is also true that some psychologists are very much oriented towards the organic and some psychiatrists (particularly those practicing as psychoanalysts) toward the non-organic. A number of diagnostic systems exist, some quite sophisticated, but there is no single universally accepted system and, in fact, much ambiguity as to whether the frequently diagnosed adolescent problem of "conduct disorder" is or is not a psychiatric problem. Finally, the paucity of outcome effectiveness research means that the "appropriate" treatment may in some cases be a matter of opinion, while fads for particular approaches may wax and wane without ever having received scientific evaluation.

Much of the confusion stems from the enormous range of problems treated under the rubric of "mental health services", problems ranging from brain damage to genetic disorder, from developmental delay to a tendency toward criminal activity. Each patient may require a unique approach both to the causes of the difficulty and to the treatment(s) required. If one approach fails it may be necessary to try another, or even to try another practitioner.

The situation resembles that prevailing in oncology. Cancer, too, is not a unitary disease, and it too suffers from too many rather than too few theories of etiology. For cancer, too, it is often unclear at the outset what treatment will be most effective. Often all treatments fail. But we do not take the imperfections of oncology as reason to scorn that field and ignore its therapies: rather we react to its imperfections by increasing funding for research. In similar fashion, the imperfections of our understanding of the causes and cures of mental health problems of children and adolescents is reason not to criticize that field but to support it. Nor should we overestimate those imperfections: some scientific research does indeed indicate that many of its treatments are indeed quite effective in many cases, while "satisfied customers" are plentiful (e.g., Kolvin 1981).

On the other hand, perhaps we should be wary of expecting too much from the field of child/adolescent mental health. As one pediatric psychiatrist pointed out, in other areas we are willing to accept that some conditions are chronic in nature. Asthma, for example, can be relieved but rarely cured. We seem to expect child psychiatrists and psychologists to be more successful with mental illness than other physicians have been with childhood asthma. (Or, for that matter, than economists have been in controlling--or even predicting--the course of the economy.) In the last analysis, many of our mental health problems are social problems closely linked to poverty and to ignorance. We cannot expect mental health professionals to solve the major problems of society.

Problem 4: Stigma

Mental health professionals tend to grossly underestimate the degree of stigma which still attaches to a "mental health" facility, particularly in rural areas. One social service worker summed up the attitude she frequently encountered among troubled young people as, "I'm not going nuts, I don't need to go to a mental health clinic." This social worker frequently deals with the potential patients the mental health facility never sees: the young people who continue to suffer problems unaided in preference to braving the stigma attached to seeking help. But mental health professionals do see those patients who have managed to overcome the stigma hurdle; basing their opinions upon their experience, they tend to view stigma as a not overly important, surmountable problem. Especially among peer group-sensitive adolescents, and particularly in rural areas, the stigma problem may be far worse than they imagine.

Problem 5

Fragmentation and the Health/Social Services Distinction

Fragmentation of services and a resulting need for their coordination are inherent aspects of bureaucratic organization. No one agency or facility can do everything for everyone. If agencies--and government departments--are to be workable then they must specialize. As chapter V ("Administrative Reorganization") discusses, our governmental services are largely organized by function: one deals with housing, another with forestry management, and so forth. When it comes to services for young people, we find one agency responsible for formal education, another for drug dependency problems, another for child abuse and foster care, another for mental illness, another for criminal activity. A troubled young person and his or her parents may come to view government and its affiliated agencies as a many-headed hydra: one hour the court intervenes, then a mental health clinic, then a drug dependency unit, then a child welfare worker, then a special education teacher. There is inevitably a strong tendency for each agency to act independently of the others, resulting in both overlap of services and gaps in service. Chapters V, VI, and VIII discuss and reccommend organizational strategies intended to minimize fragmentation and maximize coordination of services for children and adolescents.

As one ascends the bureaucratic ladder, two contradictory tendencies are likely to strengthen. "Turf" may be strongly guarded as senior officials strive to prevent other departments from encroaching on their "territory". At other times, these officials may act to prevent their own department or facility from providing services they regard as the responsibility of others. Gaps may appear, as when two departments each decide that a particular service "really" belongs to the other, so that neither provides a needed service. Less frequently, duplication may take place as two departments each feel that the provision of a particular service is its own task. But the most commonly occurring problem caused by bureaucratic separation is that departments do not reward and may even penalize personnel who cooperate too fully with other, "competing" departments, even though such cooperation is usually in the client's--and the taxpayer's--interest.

These tendencies affect all age groups, of course, but perhaps trouble young people most of all. Health, education, social services, the police and the courts—these departments or divisions of government all share responsibility for the young, so that the potential for gaps in services is huge. Each is responsible for one aspect of the child or adolescent, none for the whole human being. Each may blame the others for the problems caused by this fragmentation. For example, it is unfortunately common for a mental health facility to accuse an educational system of not providing adequately trained staff to deal with "school problems" which, however, are often perceived by school officials as mental health problems. Family court judges are generally in an excellent position to perceive gaps in services but, unenviably, are often forced to choose among options none of which they may find to be appropriate.

At times, both senior and junior personnel may fall into the trap of arguing that such-and-such a program is "really" a health service or "really" a social service or "really" somthing which should be provided by the schools. Where would a course in parenting or stress management fall, for example: education, mental health, or social services? At what point does the "social service" of family and marital counselling become the "psychiatric mental health" service of family therapy? If a child of divorcing parents suddenly fails in school, who is to take charge?

The answers to these questions do not lie in the realm of "really," the realm of Platonic essences. Government departments are organized separately from one another because to do so increases the efficiency with which services can be delivered to the public. The distinctions among health, social service, educational and correctional agencies is "heuristic," that is, made to further a particular goal, that of the efficient delivery of services. The answer to any question about which department or agency "should" provide a particular service does not depend on what that service "really" is but simply on who can, at a given point in time, deliver it most efficiently and effectively. In some places, during some periods, the schools may provide a full range of services for children. In other places and times, that responsibility may fall to hospitals, or to social service agencies, or to child guidance clinics. What is important and all that is important is that the services be provided, and be provided in a manner both effective and not unnecessarily burdensome to the taxpayer.

Whether departments cooperate or not, the fact is that all parts of the network of mental health and related services for young people are highly interdependent. Suppose, for example, a school fails to investigate a young child's learning difficulties. Perhaps the problem is neurological, perhaps the child's hearing is impaired, or perhaps the roots of the difficulty lie in family interaction. Any one of many factors may lead to early school failure. Uncorrected, the child may develop a self-image as "dumb" and his/her expectation of future school problem become a self-fulfilling prophecy. Or perhaps the child learns to cope with school failure by compensating in socially disruptive ways—unruly behavior, "juvenile delinquency" or whatever.[5] Now the child may be referred to a mental health centre. Later the child may be referred to a child welfare agency, and perhaps still later will come to the attention of the courts. Aside from the fact that the school's failure to have an "early warning" and remedial system may have blighted a life, it has also placed a burden on other facilities in the network. But there is no intention here of singling out the educational system. Perhaps, for example, the school has indeed identified the child as in need of mental health services and has referred him or her to an appropriate facility but one which gives children's services a low priority. (As one school guidance counselor remarked of the facility in her region, "all they do is hang a label on and send him back to me.")

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[5] The argument is frequently made that children with untreated perceptual disorders are likely to suffer initially from school failure and later to become juvenile offenders. For a representative discussion, see Zinkus, Gottleib and Zinkus (1979).

The lack of expertise in dealing with the problems of young people at mental health facilities burdens the schools—who may also have little such expertise. Though the interdependency of mental health, educational and social services for children and adolescents is obvious if one looks at the system from the viewpoint of the troubled youngster, it is much more difficult to see from the vantage point of any single agency. Worse, the higher the level of the viewer within any single agency the more difficult it is to see that interdependency.

Related to problems of fragmentation and coordination of services is that of the lack of long-term responsibility by any one agency for any individual young person or his/her family. Children with chronic problems may come repeatedly to the attention of one agency one year, another agency another year--or perhaps with each new episode or crisis will return to the same facility, but still without it assuming any long-term responsibility. Services tend to be swamped with assessments and short-term "band-aid" treatments and follow-up and after-care are always of lower priority than the treatment of acute problems. No agency has regular responsibility for long-term monitoring of problem children and adolescents or of problem families. Though in some cases community health nurses pay periodic visits to chronic care patients, only rarely does a young person with social/behavioral problems end up on such a register; nor is it common for community health nurses to have much in the way of time or specialized training for the mixture of social/mental health problems from which young people so often suffer.

Problem 6: Reward Systems and Incentives

Idealism is admirable but a shaky basis for a province's system of services for children and adolescents. People tend to do what we reward them for. If we want them to act consistently in the child's interest then we must not rely exclusively on dedication but must make sure that they have other incentive, incentive in terms of prospects for salary and promotion. As we have already seen, it is entirely unrealistic to advocate inter-agency cooperation while penalizing those individuals who do indeed so cooperate. Yet this is exactly what we usually do, since time spent with other agencies is often perceived by the home agency as time not working, not seeing patients/clients, etc. This perception is not so much a matter of policy as of absence of policy. For example, if "productivity" is measured in terms of number of patients/clients seen then the staff member who spends much time consulting with or aiding other agencies will be "low" in productivity: his or her career may thereby suffer. No one, after all, provides any direct reward for the extent to which a patient/client has actually been helped, or even for the extent to which he or she is satisfied with the service.

But inter-agency cooperation is just one of the desirable actions for which staff is rarely rewarded and at times is penalized. Since the reward system of a facility never takes into account the effectiveness of intervention (as opposed to number of people seen, punctuality, regularity in filling out paperwork, and absence of complaints) or the satisfaction of the patient/client, doing a genuinely good job is a matter of the staff member's individual conscience. There are indeed highly conscientious, dedicated people helping our troubled young people: the problem is that we do not reward them. The art of management lies in providing incentive for bureaucrats to do whatever it is the bureaucracy exists to do, rather than incentive for the appearance of doing it. Our mental health and social service professionals (and our corporate executives, professors, etc.) are all bureaucrats, in this context. But it takes a thoughtful and skilled administrator to be aware of his or her facility's system of rewards and to seek ways to take into account effectiveness and patient/client satisfaction (and that of their families) in making decisions regarding salary and promotion.

What is true for the individual may also be true for the agency. For example, the Department of Health must rely on such statistics as number of patient/client contacts and absolute number of individuals seen in deciding whether to permit a mental health facility to expand. The Department may have access to some qualitative data concerning reputation and appearance but it has no reliable way to know which facilities are doing a good job and which are not, in terms of the long-term effectivenes of therapeutic intervention (presumably, the most meaningful criterion of effectiveness). It is easy to detect poor performance by a facility when it looks like poor performance (poor staff morale, poor reports from other agencies, complaints from patients/clients and their families): it is not possible to evaluate accurately facilities which are able to manage their on-paper appearance. Nor is it possible to reward excellence in facility performance if there is no way to detect it.

Problem 7: Metropole-Hinterland and Inequity Problems, and Staff Shortages

In Nova Scotia, the Halifax-Dartmouth region is the "Metropole" which provides services for the rest of the Province, its hinterland. Universities, hospitals, specialists and specialized services of all kinds tend to be located in the Metropole. Residents of the hinterland must travel to gain access to these facilities. Metropole-hinterland problems are ubiquitous in Canada (which itself complains of being treated as a hinterland by U.S.-based corporations), which has so much sparsely inhabited territory and so much of its population concentrated in urban areas.

In general, it makes considerable sense for specialized medical services to be concentrated in a metropolitan area. Given the size of Nova Scotia only the Province as a whole is a sufficiently large catchment area to justify the existence of specialized facilities in the first place, so that these facilities must serve the entire Province. Then, too, professionals prefer to work in urban areas and, moreover, tend to demand colleagues. Facilities seem to require a "critical" mass of professionals in order that none feel isolated, cut off from the mainstream of his/her profession.

Unfortunately, from the point of view of the hinterland the Metropole is always seen as an exploiter, enjoying a disproportionate share of available resources. Metro-based specialized facilities whose justification is that the entire Province is the catchment area are looked upon with jaundiced eye by those in regions requiring many hours of travel to utilize them. Their reaction is to demand that the facilities be located outside Metro, where, however, they may be even harder to justify in terms of population served and where they may have special problems in attracting personnel.

The problem is especially acute where children's services, especially mental health services, are involved. The mental health community is in resounding agreement that children are best treated at home; when that is not possible, they should be treated in their own community. However, most of Nova Scotia's child and adolescent mental health experts and facilities are located in Metro.

It is important to be aware of the special problems rural areas have in the provision of services to young people. First, community support services, vital if mental health facilities are to be effective, are often lacking. Second, travel time, especially in winter, is likely to be a continuing problem. Either the patient/client must frequently travel, or the mental health professional must do the travelling (as in satellite clinics), or both. Third, rural areas are often more conservative than urban regions, more likely to be suspicious of outsiders. This is especially true when the outsiders are mental health workers. Fourth, as was already noted, professionals tend to fear isolation, so that both recruitment of staff and retaining those already recruited may be problematic. Fifth and finally, local family practitioners may distrust the mental health professionals, often seeing them as rivals. A "country doctor" is accustomed to performing many services for which an urban practitioner would be likely to refer to a specialist. Mental health professionals cannot count on automatically receiving referrals from rural family physicians.

Staff Shortages

The Metropole-hinterland problem is exacerbated by the continent-wide shortage of professionals with expertise in the problems of children and adolescents. As was mentioned previously, such experts tend to prefer to live in urban rather than rural areas. Thus, the Halifax-Dartmouth area has most of the Province's child/adolescent mental health expertise. But recruitment of personnel even for the Halifax-Dartmouth region is often quite difficult: unfortunately, many professionals, well-trained in their respective fields but ignorant of the Maritimes, consider even Halifax-Dartmouth a hinterland.

In the rest of the Province, staff shortages not infrequently breed a martyr cycle. Existing staff, in response to need, often work very long hours —60 hours a week and more, plus occasional calls in the middle of the night. When attempts are made to attract new staff, these fresh individuals look at the workload of those who would be their colleagues and often seek less demanding pastures. Their reluctance to be recruited leaves their would-be colleagues trapped in the martyr cycle. Chapter XI offers a number of recommendations to alleviate staff shortages.

Problem 8: The Changing Family and Government Responsibility

In the small-scale societies in which our ancestors lived the family was everything and government an unnecessary abstraction. A family member was priest, a family member was physician, a family member was advisor and counselor; and everyone worked and taught and buried the dead together. But the family has gradually hived off its responsibilities, one by one. Now specialists are responsible for the education of our children, specialists are responsible for our health, specialists are responsible for our religion, specialists attend to our births and our funerals; and specialist strangers counsel us when our marriages are troubled, when we have difficulty in raising our children, and when we are simply unhappy. Some members of the public, rather than resisting the trend for the family to lose both responsibility and authority, wish to hasten it. Thus, child welfare agencies regulary report parents bringing their own troublesome offspring to them and angrily saying, "I have looked after that so-and-so for X years, now you do it!"

Mental health and related facilities are, along with the schools, the focus of this push towards family devestiture of responsibility. To what extent are they to respond to it? To what extent should these government-supported services be teaching people how to live their lives, live with others, raise children? To what extent can government—the taxpayer—provide without charge the kinds of services kin (and clergymen) once and to a considerable degree still continue to supply, services under the rubric of counselling, life skills, and "how to cope" advice?

It is interesting to note that both mental health and child welfare personnel feel that families are pushing them to accept unwanted responsibility, and these agencies report that they expend much effort in pushing the responsibility right back to the family. For example, there is generally a demand on the part of mental health agencies that the parents or guardians of a troubled child or adolescent cooperate fully in therapy. In addition, the agencies tend to perceive themselves as striving to strengthen the family: that may be one reason why family therapy is quite popular at some facilities, and why there is much interest on the part of both social service and mental health facilities in making parenting courses available.

Though both mental health and child welfare personnel tend to actively promote an increase in the family's responsibility for its members, there is one case in which they often express ambivalence: the right any woman or couple has to start a family. We thus arrive at the subject of the multiproblem family.

Multiproblem Families and Pockets of Appalachia

One experienced pediatrician described the chief cause of children with emotional and behavioral difficulties as, "parents with inadequate personalities having children with inadequate personalities." So far, at least, there are no licensing requirements for parenthood. Nor does this Study recommend that there by any.[6] Having children is a vital civil right, but let us be honest in admitting the dreadful price we pay for this privilege. Young women, themselves suffering from intellectual and emotional handicaps, have the right to raise and bear any number of children; only in extreme and legally demonstrable cases of neglect or abuse can a child welfare worker interfere. Couples with the most serious problems of marital adjustment, or ignorant of the most basic knowledge of how to be parents, are free to raise large families.

The problem of emotional and social difficulties perpetuating themselves from one generation to the next results from the wounded unwittingly wounding their own children. Families in which several generations are quite well known to the social service workers, mental health staff, and local police are quite common. Here and there, in Nova Scotia, are pockets of what Leighton (1965) has called "depressed areas" and "socially disintegrated" communities, of what one social worker referred to as "pockets of Appalachia". But these pockets are hardly limited to the Province's rural areas; one urban family court judge pointed out that many of the young people brought before him come from a readily identifiable neighborhood in his city.

Any experienced community health nurse can point out the communities and families whose children are likely to come to the attention of mental health and social service agencies. One such nurse, returning from a post-natal visit to a mother, remarked that the infant would eventually be "getting into trouble." After all, she commented, the five or six previous siblings were already having school and in some cases legal difficulties, and were already occasional visitors to the local mental health facility. In another case, a community health nurse described how she had been about to suggest to a father that he seek a speech remediation program for his son; but when the father replied she realized that he shared with his son the same pattern of almost unintelligible speech, and he did not perceive it as a problem! She held her peace, though the youngster in question is quite likely to suffer from incomprehensibility—and all its attendant problems—for life.

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[6] On the other hand, an article in the 28 October 1981 issue of MacLeans Magazine, "Suffer the Innocent Children" (by Joy Fielding), considers whether people who abuse their children should forfeit the right to have them.

Aside from their human cost, multiproblem families burden the entire system of mental health, social service, and educational facilities. One British study (Oliver and Buchanan 1979) documented the immense amount of multi-agency help one such family received and how, despite the dedication of the public health nurses and social workers most directly involved, their efforts were largely futile. The study concluded that it would have been far wiser to have concentrated all resources on aiding the children, perhaps thereby breaking the generation-to-generation transmission of this catastrophic situation. Another approach involves using mental health experts as "catalytic agents" to promote community change rather than focusing on individual families (Cardoza, Ackerly & Leighton 1975). The techniques required are long-term in nature and require great commitment on the part of both staff and facilities.

Problem 8: The "Impossible" Child

"What do we do with children who are not crazy and who have not broken the law" but whom no one wants, asked one psychiatrist, while making it clear that his facility was definitely not the place for them. Our society has not yet decided what it wants to do with children running wild, children whose parents cannot cope with them. In Nova Scotia, such young people are likely to be bounced about from the School for Boys or the School for Girls to the Nova Scotia Hospital to a group home to a foster home . . . but always in motion. These are the "unmanageable children" who do not quite fit into any existing facility and whose problems are likely to be defined by social service personnel as "psychiatric" and by mental health personnel as "social". Naomi Rae-Grant (1978) labels the syndrome the "Ovinnik" syndrome "after an antisocial spirit in Slavonic mythology." These children have poor capacity for relationships with order, are anti-social, suffer from school problems and are often self-destructive. Though the prognosis is generally poor for such children, the more successful programs (according to Rae-Grant) are marked by staff commitment, often lengthy stays at residential facilities, membership in some kind of family-type unit, after-care and continuing contact with that family-type unit, an individualized program, adequate staff/patient ratios, and opportunities to learn both individual and group skills.

Problem 9: "Group-Think"

Given strong leadership, a mental health facility can often overcome disciplinary rivalries and achieve considerable solidarity. When this occurs it becomes susceptible to "group-think". Once the facility as a whole is wed to particular policies regarding therapies to be provided, triage, etc., then any staff member who challenges that consensus appears to be disloyal. Individuals self-censor themselves at meetings, and often come to accept the shared beliefs as self-evidently true. Both as a group and as individuals, staff either avoid or rationalize away information which would challenge the group's consensus. Outsiders can readily diagnose group-think, the symptoms involving pride in foolish policies and rigidity in maintaining them (e.g., insisting that the facility is essentially consultative in nature and that the referring agent must be responsible for the actual treatment, regardless of the referrer's obvious inability to provide the treatment; or getting itself wed to a faddish but unproven type of therapy). Senior administrators can combat tendencies toward group think in facilities under their jurisdiction by encouraging staff members' attendance at professional meetings and by making continuing education opportunities available. Lateral transfers, so that staff members are exposed to non-group members, can also be helpful.

Summary of Chapter II, "Introduction"

1. Our problems in delivering mental health and related services to children and adolescents in Nova Scotia are not unique. The following list of disturbing processes recur everywhere and must be attended to on a continual basis rather than resolved once and for all.

2. "Professional rivalries" chiefly, in Nova Scotia, involve psychatrists vs. doctoral-level psychologists vying for supremacy in the control of mental health services. Where the one actually wins the battle it becomes difficult to recruit the other.

3. The "scope of the field" problem is related to the fuzziness of the term "mental health," which can at times mean "mental illness." Its ambiguity is mirrored by the ambiguity of the mission of many mental health facilities, concerned as they are with conflicting demands for "prevention" vs. care of the acutely ill, and with treating "problems of living" vs. serious illness. It is very rare for a facility to set forth clear priorities in, for example, treatment services, or in the division of treatment programs between children and adults.

4. The "state of the art and unrealistic expectations" confound mental health services, particularly services needed by young people. The field itself is confused, with some experts emphasizing organic explanations and treatments for disorders, others explanations in terms of social deviance and errors of learning. Some disorders, particularly conduct disorders, are extremely difficult to treat effectively. The public, however, while it may tolerate chronic asthma, expects "cures" from the mental health field.

5. "Stigma" remains a major problem in dealing with mental illness. Mental health professionals, who only see patients who have managed to overcome the stigma at least somewhat, tend to underestimate its strength, particularly in rural areas and among adolescents.

6. "Fragmentation" and the "health/social services distinction" refers to the fact that no one agency is responsible for the troubled young person. Rather, an agency is responsible for an aspect of a problem, and then only until the "case" is referred elsewhere. Some young people are bounced from agency to agency. At the same time, competition among departments tends to inhibit real cooperation, preventing the development of programs which are neither clearly the one nor the other. No one takes long-term responsibility for the troubled young person.

7. The "reward systems and incentives" of mental health facilities and social service agencies tend to reward—in the sense of furthering the careers of—those who "stay out of trouble" and do not "waste" too much time cooperating with other agencies. Since the system has no way to determine if a patient/client has or has not benefitted from treatment, there is no way to reward the more effective professional. Thus, we have to rely on idealism on the part of the most effective and hard-working staff mem-

bers. In similar fashion, since there is no way to determine the effectiveness of the programs and policies of a facility, we necessarily reward those facilities which appear to be efficient and effective.

8. The "Metropole-hinterland" and "inequity" problems. In Nova Scotia as elsewhere, specialized services require high population density to be efficient. This usually concentrates such services--including specialized facilities for children and adolescents—in a single region (in this case, the Halifax-Dartmouth area). The rest of the population, more thinly spread out, complains of the inequity and demands its own specialized facilities.

9. "Staff shortages" are closely linked to the metropole-hinterland problem because mental health and related professionals with expertise in children and adolescents are quite rare through-out the continent, and many professionals do not wish to live in the rural "hinterland." Thus, non-Metro areas have major problems attracting professionals, who are likely to complain of being professionally isolated and who are also likely to be overworked due to their rarity.

10. The "changing family" is a problem in that we as a society have not yet decided whether we wish to continue to transfer responsibility for children and adolescents to government. Child welfare and mental health facility staff tend to feel that some members of the public wish to shift most of the responsibility for their children to these agencies, expecting them to look after and to "cure" their troublesome offspring. The response of the agencies is to try to strengthen the family through, for example, family therapy and courses on parenting. No one challenges the right of the individual to start a family, however, no matter how unprepared he or she may be.

11. "Multiproblem families" are families which have a range of economic, social and mental health problems. Often the parents of these families themselves have come from multiproblem families, in a generation-to-generation transmission of social malaise. It is entirely unrealistic to expect any agency, whether mental health, social service, or school-related, to be very effective in tackling the myriad problems of a multiproblem family. Rather, each agency applies a band-aid and the problems march on down through the generations.

12. The "impossible child" is the expressive term professionals use to refer to those troublesome children and adolescents whom no one wants. It is unclear (and perhaps unimportant) whether they are to be considered social problems or psychiatric problems. At present the Province has no appropriate facility for them. Usually they will spend some time at both the Nova Scotia Hospital and at either the Nova Scotia School for Boys or the School for Girls, but none of these facilities feels it is appropriate for "impossible" children.

13. "Group-think" is the social psychological phenomenon which has locked the U.S.A. and U.S.S.R. into an arms race. Once a group has developed solidarity around a fixed set of ideas any challenge to them--especially challenges based on data—are interpreted as disloyalty. Individuals often self-censor to avoid this charge, and, frequently, reality. It locks mental health facilities into maintaining, for example, that no child may be seen without a prior physical examination, or into an insistence that the parents must cooperate fully or the child will not be treated. Rigidity is a symptom of group-think.

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Chapter III

PREVENTION AND POLICY GUIDELINES

> Those of us who are enthusiasts for the control and prevention of mental illnesses, like other enthusiasts, commonly regard those who oppose us as malign. Yet the core of the issue — the generally overlooked core — is not willingness to give vs. mean selfishness, or humane concern vs brutal indifference, real as these are. The core of the issue is the management of limited resources, of making choices among many different kinds of humane goals, as well as among objectives that are necessary for human survival. Over-population, poverty, malnutrition, child mortality, displaced people, crime, nuclear control, environmental pollution, and national defense are only a few of the other great problems that absorb money and qualified personnel. (Alexander Leighton, 1982, Caring for Mentally Ill People, p. 16.)

The topic of prevention was deliberately omitted from the preceding chapter: it needs space for itself. No subject arouses quite so much anger and indignation among those concerned with mental health as does prevention and lack of prevention. And no issue is quite so confused.

Advocates of prevention in mental health argue along these lines: Public health measures have been miracles. Modern programs of sanitation and immunization have eliminated in North America most of the child and infant mortality that even at the beginning of this century were accepted as unavoidable. If we can wipe out smallpox and practically eliminate typhoid, typhus, diptheria, malaria and whooping cough (pertussis), why not mental illness? Moreover, preventive mental health measures certainly must be cost effective, given the great expense of institutionalization or even of outpatient treatment. Our mental health facilities must therefore make prevention their highest priority.

Critics of prevention in mental health (e.g., Coleman 1978, Leighton 1982) urge not so much that it be avoided entirely as that the topic be approached with caution. First, they argue that it is unclear what prevention programs are intended to prevent. Typically, stated goals are so vague—or non-existant—that it becomes impossible to identify either success or failure. Then, too, rarely are prevention programs based on scientific knowledge (Zigler and Trickett 1979). Rather, they tend to be popular fads for a time which are discontinued when the fad wanes. The mental hygiene movement of the first part of this century (associated with Adolf Meyer and Morton Prince), the child guidance movement of the 1920s and the community mental health movement of the 1960s were all oriented toward prevention but it is quite unclear as to whether anything was indeed prevented. Moreover, it is too easy for "preventive" programs to drain off funds needed for acute care of the already ill. This last point represents a serious danger.

The literature on prevention speaks of a continuum of effort which is usually divided into three categories. Primary prevention refers to the prevention of new cases, that is, the reduction of the incidence of a disorder. Secondary prevention deals with early detection and prompt treatment of illness. Tertiary prevention has to do with reducing the after-effects of illness and with rehabilitation efforts in general. Discussions of prevention of mental illness usually focus on primary and to some extent secondary prevention. [1]

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[1] In February, 1981 a Federal Symposium on Preventive Strategies in Child Mental Health was held in Toronto and its papers subsequently made available by the Health Services and Promotion Branch of Health and Welfare Canada. That symposium showed that there is considerable enthusiasm among Canadian mental health professionals for preventive programs, though many papers expressed caution as well. The symposium also demonstrated considerable Canadian competence in this area (though Nova Scotia was apparently not represented among the contributors).

In Nova Scotia, most preventive efforts are the responsibility of the Administrator for Community Health Services, and, under him, the Health Units. The community health nurses attached to these units, for example, pay expectant mothers pre-natal and post-natal visits, maintain a chronic care register and visit separated hospital patients (including those separated from psychiatric hospitals or psychiatric wards of other hospitals). But some of the Province's mental health facilities feel that they, too, have an important preventive role, at least with regard to mental health.

In the 1950s and 1960s, under the influence of the Canadian Mental Health Association and federal and provincial programs, community mental health centers were created throughout Nova Scotia. These facilities had many differences but they did share a strong orientation toward prevention, usually interpreted as community programs, the teaching of courses in stress management and parenting, and in some cases community activism. In the latter 1970s, however, most mental health centres were merged with hospitals. Some centers have retained much of their autonomy and sense of mission and so continue to emphasize prevention. Others are now simply the psychiatric departments of hospitals, and hospitals expect that staff will concentrate on providing services within the institution and to the acutely ill. Even in those cases where mental health facilities feel they are succeeding in maintaining their preventive mission, they report considerable tension with hospital administration. Regardless of whether the now-amalgamated mental health centers are or are not providing what they regard as preventive services, resentfulness and even bitterness over the amalgamation remain strong among many older staff members, and it is the perceived loss of commitment to preventive programs which appears to be regretted most.

Approaches to Prevention

Though the primary/secondary/tertiary categorizations are of some use in clarifying dicussions of prevention, additional distinctions are needed. The distinctions discussed below are not intended to be mutually exclusive.

1) A prevention program can be applied to all children, or it can involve only selected groups believed to be more likely than others, in the absence of any intervention, to develop behavioral or emotional problems. Such target populations are said to be "at risk" of a disorder and are referred to as "high risk" groups. A mandatory high school "Family Life" education program, for example, would be an "all children" type of prevention program. A film on coping with the break-up of one's parents' marriage, shown only to students of divorced or divorcing parents, would be an example of a program specifically for a "high risk" group (since some professionals believe that children in these circumstances are at risk for behavioral/emotional problems).

2) A program can include a number of "enrichment" and "help-the-child-realize-full-potential" goals while also being described as "preventive" in nature; or it can have as sole or at least major goal the prevention of mental illness. In point of fact, most "prevention" programs are closer to being multi-goal efforts at enrichment than limited to mental illness prevention strategies.

3) A program can be intended to promote mental health in general (e.g., a stress management course) or it can have a specific disorder as target (such as screening newborn infants for grossly elevated levels of plasma phenylalanine, whose presence indicates the mental retardation-causing genetic disease phenylketonuria).

4) A program can be based on repeatedly and unambiguously replicated scientific research (e.g., the phenylketonuria example discussed above) or it can represent the "educated guess" of mental health and other professionals. Most prevention-through-courses-at-school is of the latter type. Whatever their long-term effects on mental health, such non-research-based efforts usually reflect our own culture's values and morality, e.g., that compassion is to be valued and that empathy automatically leads to it.

5) A program can have a clearly specified goal or set of goals, permitting future evaluation in terms of their attainment; or it can have vague goals (e.g., the improvement of mental health) which are impossible to measure.

6) A program can be clearly aimed at mental health (e.g., discussion groups for adolescents) or can promote mental health indirectly largely by promoting physical health. The 1980 report of the Canadian Senate's Standing Committee on Health, Welfare and Science, prepared by its Committee on Early Childhood Experiences as Causes of Criminal Behaviour and entitled Child at Risk, includes many recommendations far removed from actual criminal activity. For example, it recommends proper pre-natal and post-natal care and nutrition, the cautioning of women about the effects of smoking and of alcohol and other drugs on the fetus, the encouragement of early mother-infant bonding and breast-feeding, and the strengthening of home visitor programs.

7) A program can be aimed specifically at mental health, or it can have all deviant behavior as its target (as in the case of many of the Child at Risk recommendations mentioned above).

Guidelines

Much of the controversy over mental health prevention effort can be eliminated by making use of the conceptual distinctions discussed above and by following the guidelines provided below. These guidelines are intended as formal recommendations.

1) Programs which are worthy ends in themselves should not be portrayed or justified as "prevention" programs. Day care facilities, courses on parenting and stress management, crisis intervention centers, voluntary organizations such as Big Brothers/Big Sisters, family life education courses in the schools — these are all worthy and valuable in themselves. As Alexander Leighton has pointed out, even if we were to discover that they did not reduce the incidence of mental illness we would certainly retain them. Whatever their effects on mental health, we nevertheless value and need such programs. Promoting them as "prevention", however, promises too much and risks their eventual condemnation on the grounds that they failed to fulfill that promise by, for example, reducing the incidence of schizophrenia or manic-depressive psychosis. Helping people with problems and providing needed services to the public are justified even without claims to "prevention".

2) Again following Leighton, there must be clear budgetary separation between services for the acutely ill on the one hand and for prevention on the other, lest the one prosper at the expense of the other. Funding for the federal government's "participaction" program does not compete for funds with the payment schedules of family practitioners. In the same way, provincially supported preventive mental health programs should not be competing with acute care or hospital budgets but with, say, programs for reforestation or support for the fisheries.

3) All primary and secondary preventive programs should be organized as research projects with clearly stipulated goals in order that their effectiveness — and worthiness to be continued and expanded — can be objectively evaluated. Even where prevention is only a secondary aspect of a program whose primary goal is to provide needed services (e.g., special education for children with school problems) the prevention goals should either be clearly specified or the subject of "prevention" omitted.

The first of these guidelines appears to be uncontroversial and to require little discussion. It is simply not in the interests of those who support programs such as day care facilities to claim too much for them; nor is it necessary that they do so. The latter two guidelines, however, do require further analysis.

Budgetary separation between preventive programs and those serving the acutely ill at first seems simple and practical enough, particularly when the former is under the authority of the Administrator for Psychiatric Mental Health Services and the latter under the Administrator for Community Health Services. In practice, however, as was previously noted, some mental health facilities see prevention as one of their primary goals. Thus, the same people and budget providing acute care services are also, in some cases, providing preventive services as well. Some of these individuals presented three arguments for their continuing to divide their time between prevention and acute care: a) There will never be enough staff to treat all who might require it so it makes sense to devote resources to prevention in the hope of reducing the number of potential patients/clients in the future. b) The people best qualified for prevention work are those who are now treating the ill. c) Mental health professionals need activities other than providing treatment for the sake of their own mental health!

The first of these arguments may be true but is not relevant. The issue is not whether we should be engaging in prevention — we should — but who should be doing it. In Nova Scotia, prevention is the primary responsibility of the community health nurses of the Health Units. The second argument is relevant but not necessarily true. Surely someone trained in preventive work may be as well qualified to perform it as one trained in direct care. To the extent that research yields reliably effective preventive programs, to that extent we can train experts in these programs, rather than divide the efforts of those primarily trained in providing treatment to the ill.

But the last argument, that mental health professionals need alternative but worthy professional activities, does carry weight.

Often enough, as one visits mental health facilities, the strain and drain of providing treatment services is marked on the face and carriage of staff members. "Burn-out" is a major problem in the helping professions, one of the reasons for the shortage of professionals. Even from an efficiency viewpoint, if providing courses on parenting or if counselling teenagers helps prevent burn-out then staff members should be permitted and even encouraged to do so. However, mental health staff are hired to spend most of their time providing direct treatment services. Thus, it would be wise to restrict the proportion of their prevention activities to no more than 20 percent of their total working time.

Our ultimate hope of reducing the incidence of mental illness does indeed rest with prevention rather than with the impossible task of providing enough treatment services. There will never be enough, given the potentially massive demand. But we do not know with any certainty which of our various preventive measures work and which do not.

Prevention, however, is simply too important for us to wait until the researchers can assure us that such-and-such a program is indeed effective. The solution is to continue with our prevention efforts while making them simultaneously into research projects. Thus, in the future we will have programs that represent something better than educated guesses.

A research component, however, cannot simply be added to a prevention program but must be a necessary part of its conception and design. At a minimum, the goals of the program must be defined in measurable terms, in order that program effectiveness can later be evaluated unambiguously. Control groups must be planned in advance. Staff with research experience and skills must participate in the program (as opposed to those whose training has been primarily clinical in nature).

Offord and Jones (1982) provide a model of a carefully controlled preventive/research project. They target not mental illness per se but antisocial behavior. By teaching skills ranging from guitar-playing to hockey to the approximately 417 children between the ages of 5 - 15 living in a publicly-supported housing complex in Ottawa, they hope that the self-esteem and school performance of these young people will improve, in comparision with a control group; and that their rate of antisocial and delinquency behavior will diminish (again, in comparison with a control group). Unlike most "preventive" projects, we will know at the conclusion of their work whether such programs are worth mounting.

High Risk Groups and Screening

High Risk Groups

To the extent that mental health staff engage in preventive activities, they should focus their efforts on children and adolescents (and families) in high risk groups. Given that only a limited amount of resources are available for prevention, after all, it makes sense to concentrate on those most likely to be in need of attention. The problem is, how do we identify the at-risk groups?

Bolman and Bolian (1979) view crisis intervention as a form of prevention. They restrict their discussion to "crisis intervention programs where there is reasonable evidence of effectiveness" (p.228). These authors distinguish between biomedical intervention programs and psychosocial intervention programs. Among the target groups of the former are (p. 230):

1) Pregnant women in low-income high-risk groups.
2) Unwed pregnant adolescent girls.
3) Families with a child requiring special care.
4) Families with more children than they can manage.
5) Individuals with familial or inheritable disorders.
6) Pregnant women generally.
7) Children with chronic illness.
8) Children exposed to stressful events (hospitalization).

Under target populations for "potential psychosocial intervention programs", Bolman and Bolian (p. 231) list:

1) Families with loss of a member....
2) Families with a severely ill parent (mental illness, alcoholism).
3) Families in conflict (separation, divorce).
4) Abusive families.
5) Families under stress due to vulnerability to normal developmental events (birth of a child, school entry).
6) Families in poverty.
7) Families with stressful role handicaps (adoption, step-parent...).
8) Teen-age parents.

It is important to note, whenever we make "at-risk" predictions, that the majority of children in the high-risk category will not fall victim to the problems for which they are believed to be at risk (Kent and Rolf 1979). It is also important to note that even Bolman and Bolian (1979:227) confess (in a chapter appearing in the prestigious Basic Handbook of Child Psychiatry) that despite the common expectation among clinicians that "it should be possible to identify and help high-risk families and children," they know of "no well-controlled studies to support this assumption" (italics omitted).

Well-controlled or not, Colletti (1979) finds that pregnancy and birth complications are associated with subsequent diagnosis of learning disability and lower than average academic achievement. Green (1978) finds considerable evidence of psychopathology and deviant behavior among abused children. Janes et al. (1979) and Janes and Hesselbrock (1978) find, in a twelve-year follow-up study, that teachers' ratings of anti-social behavior and inability to get along with others are a useful predictor of antisocial behavior in adulthood. Robins (1978), too, finds that adult antisocial behavior is almost always preceded by antisocial behavior in childhood and adolescence.

The literature on high-risk groups is large and growing. The above references merely sample it. But it seems apparent that prevention programs should be aimed at at-risk groups. From the state of the literature it is also clear that any such programs need a strong research component to permit subsequent evaluation of effectiveness.

Screening

One way to identify target groups for prevention programs is through screening procedures, most often involving testing. There is strong support (evidenced during the public meetings which were a part of this Study) for screening for learning disability in particular. McConville (1981), however, concludes that "the ability of such tests done in kindergarten to predict school achievement beyond grade 1 is generally poor...." Screening techniques are often unreliable, especially when the results of a single instrument are evaluated without reference to other data.

But problems with the reliability of tests used for screening are less fundamental than objections to their validity and to the validity of the conceptual framework behind them. Coleman (1978) argues forcefully that most (non-biological) screening devices — teachers' ratings, psychological tests, etc. — are applying a medical model to children who are not sick. The "developmental disorders" they find (with the exception of identifiable, organic problems) are not actually diseases: they are signs of social, educational and behavioral deviance (p. 67). Ensuing treatment, Coleman argues, may actually harm many of these children, particularly if drugs are used. Moreover, many children will be given stigmatizing labels by being placed in mental disorder diagnostic categories. Ultimately, the process involves "blaming the victim" of social problems for the social problems from which they suffer.

Coleman's arguments bring to mind Chapter III's discussion of unresolved disputes in the mental health field: First, do we look at behavioral/emotional problems as comparable to physical illnesses, or as deviant behavior resulting from learning to behave — or choosing to behave — in ways that are not socially acceptable? Second, are the problems of young people best treated in terms of individual therapy, or should we devote ourselves to eliminating the social conditions which are believed to cause individuals' problems? Unfortunately, both sides of each of these questions are right. Some behavioral problems are primarily organic, some a matter of learning and choice, and many are both. Naturally, we should strive to help troubled individuals, but we should also be striving to eliminate the social conditions which cause much of the trouble.

Coleman's arguments are chiefly useful for their sounding of a cautionary note. But the addition of a research component to any screening-preventive program will do much to help us avoid future evil. If the programs are not working, for whatever reason, or if they are doing harm to some children, then the evaluation process built into them should let us know. But perhaps an additional precaution is necessary, here: We should only screen for problems for which we have treatment programs of proven effectiveness already in place. There is no point in labelling a child as "learning disabled", for example, if we have no intention of doing any more than tying him with a tag.

Chapter III, "Prevention and Policy Guidelines"

1. Programs which are worthy ends in themselves should not be portrayed or justified as "mental health" prevention programs (e.g., day care centres, courses on parenting).
2. There must be clear separation between services for the acutely ill on the one hand and for prevention on the other, lest the one prosper at the expense of the other.
3. All preventive programs should be organized as research projects with clearly stipulated goals in order that their effectiveness—and worthiness to be continued and expanded—can be objectively evaluated.
4. Since engaging in "preventive" work appears to help mental health facility staff to avoid "burn-out", direct treatment staff should be permitted and even encouraged to work at "prevention" for a maximum of 20 percent of their work time.
5. To the extent that mental health staff engage in preventive activities, they should focus their efforts primarily on children and adolescents (and their families) in high risk groups.
6. We should only screen for problems for which we have treatment programs of proven effectiveness in place.

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CHAPTER IV

WHAT WE ARE DOING NOW: STATISTICS

The statistics in this section are like democracy: exasperatingly full of flaws until one thinks about the alternative. The alternative to using existing data is to collect new information: With several times the budget and staff of this Study it would have been feasible to gather independent and more reliable data by, for example, stationing research assistants in each mental health facility to gather their own information on activities and so not rely on the records kept by the facilities themselves and by the Department of Health. At the same time, physicians might have been asked to fill out a questionnaire for each young patient. A future study may wish to follow these paths. For the present Study, however, it seems unlikely that the existing data used are so inaccurate as to affect major recommendations. (A recommendation discussed below will deal with improving the quality of mental health data routinely gathered by the Department of Health).

The data presented in this section are from two sources, the Province's Department of Health and the Nova Scotia Health Services Insurance Commission. The Department of Health information is collected when mental health staff fill out various forms in order to register patients/clients, record contacts, and terminate treatment. The Health Services and Insurance Commission data are those resulting from the process whereby physicians in private practice bill MSI (Medical Services Insurance) on a fee-for-service basis for treating patients. We will begin with the Department of Health material, kindly supplied by Ms. Susan Urquhart, Director of Health Care Statistics.

Department of Health Data

Most mental health patients/clients are outpatients. When they are first seen, an "Outpatient Registration Form" is filled out. In addition, a "contact form" is used each time a patient is seen or otherwise communicated with, or whenever a staff member has contact with anyone on behalf of the patient or as part of assessment or treatment. The contact form is also used to terminate treatment. Mental health inpatients are registered at psychiatric hospitals with a "Psychiatric Admissions" form and discharged through a "Separations" form. General hospitals use their general admission and separation forms, which have less psychiatric information than the psychiatric hospital equivalents. Relatively few young people receive psychiatric admissions to non-psychiatric hospitals, however.

A peculiarity of the outpatient registration form is that many items are optional. Most facilities do not routinely fill out most of the optional items, making them very difficult to use for research purposes. These items include: family size, number of siblings, religion, race, occupation, education, marital status, living arrangements, employment status, income, reason for referral, presenting characteristics, problem rating, staff involved, and designated principle therapist. Without these "optional" items it is impossible to describe the population served by outpatient mental health services except in terms of age and sex (which are obligatory items). Several individuals requested that this Study investigate the allegation that certain mental health facilities catered to particular social classes (i.e., that such-and-such a facility was "middle class" while the working classes went elsewhere). Given that the data needed for an index of social class are considered "optional" this question, among many others, could not be addressed. Clearly the Department of Health collects information primarily for administrative rather than research purposes.

More serious problems arise with information based on the "outpatient contact form". The chief source of difficulty here is not the optional items but the fact that the form is filled out, when it is filled out, in a highly variable manner both from centre to centre and individual to individual. One area of ambiguity (shared with the outpatient registration form) is the question of who the patient is.

Table 20 on p.94 shows that 31.1 percent of outpatient treatments in mental health facilities in 1981 involved family therapy. When the diagnosis is that the primary problem involves family dynamics, the concept of individual patient/client misleads. A child-oriented facility is likely to make the child or adolescent the patient or client automatically, while others may take the parent as the individual being treated. The present data collection system gives us no way of knowing how often the family, rather than an individual, is the real "patient", or what biases affect choice of patient/client for record keeping purposes.

There is also drastic variation in the scrupulousness with which mental health facilities use these forms. The instruction manual prescribes that the outpatient contact form be filled out for all communications pertaining to a case, including third-party and telephone contacts. Some staff members tend not to use the forms except when the actual patient/client is seen, while others are punctilious in filling them out. One facility has its staff fill out both the registration form and a contact form for the first visit, while the others use the contact form only for subsequent visits. At times, two or more staff members will see a child or adolescent together. In principle, only one should fill out a contact form (except that all psychiatrists must fill out forms) but practice varies widely. In similar fashion, when two or more family members are seen together (as in family therapy), as many contact forms as people seen may be filled out, or else only a single one. Thus, in the somewhat unusual event that two therapists see three members of a family at once, there may be anywhere from one to six contacts recorded, depending on the practice of the staff members and facility involved.

The outpatient contact form is also used by the Department of Health as a measure of the number of cases open at any given time. Here we have a most peculiar situation. The computer program which processes data from the contact form automatically "lapses" a case 90 days after the "anticipated number of weeks to further appointment" have passed. One facility utilized this system to close all of its cases (at the time of this Study), otherwise never formally marking a case closed. Another facility automatically indicates one week as the "anticipated number of weeks", so that all of its cases are lapsed by the computer three months and one week after the last contact, even though the case itself is considered by the facility to be open and, in fact, there may well be an appointment arranged for three or six months in the future. On his/her return, the patient will count as a "new" registration. It is clear, therefore, that the outpatient contact forms provide somewhat unreliable data as to number of cases open.

There are also problems regarding the accuracy with which they are filled out. For example, for the outpatient registration form the instruction manual explains that if a patient is 15 years of age or under, the "employment status" to be indicated is that of the parents. If the patient is over 15 then the employment status of the patient himself/herself is to be given. But one facility, for 1980, reported that 3.6 percent of the 16-19 year old group were retired. Presumably the staff members filling out these forms were giving data pertaining to the patients' parents. Similarly, for another facility the percentage of 16-19 year old retirees was 12.5 percent, for another 4.6 percent, for another 4.8 percent, and for another 4.1 percent. Aside from the fact that obviously these data are incorrect, the question must also be raised as to whether or not it is worthwhile collecting employment status information. It may be that, for research purposes, employment status of parents would indeed be of interest. On the other hand, it might be that employment status is so changeable that it is not in itself particularly useful.

In similar fashion, the outpatient registration form asks for marital status, indicating that for age 15 and under the data should pertain to the parents and for over 15 to the client/patient himself/herself. We note, in a table deliberately not included, that for one facility 60 percent of the 16-19 year olds were married—a rather unlikely figure.

Thus, it is clear that mental health facilities should be paying increased attention to training their people in filling out the forms correctly.

Despite their various imperfections, this Study will nevertheless make use of some of the data supplied by the outpatient registration and contact forms. This is because the errors in these data are not systematic in nature. They are the equivalent of "noise", obsuring trends, perhaps, but at least not creating them where they do not in reality exist.

Recommendations Pertaining to Data Collection

Two recommendations arise from this discussion. First, there should be centralized training across facilities of staff responsible for filling out the forms which generate the data. The goal here is that all forms be filled out in a uniform manner across both facilities and individuals.

A second recommendation is that the Department of Health create a committee to review its data collection and analysis procedures with respect to psychiatric outpatients. This committee should include at least one professional researcher likely to use the resulting data in program research; one administrator likely to use the resulting data in administering mental health services; one individual whose daily work requires him/her to fill out these forms. (The latter member of the committee is essential in order that it not produce too burdensome a form for routine use.) The Committee should begin its work by focusing on the purposes for which data are to be collected.

There is no doubt that the data already being collected by the Department of Health are a useful tool in understanding how our outpatient mental health delivery system for young people operates. Nor is there doubt that, if the two above recommendations were implemented, the data provided would prove yet more valuable.

Description of the 0-19 Population

Table 1 breaks down the province's population by age, sex, and county, using data from the 1981 census. Figure 1 illustrates the same data except that sex is not included and the age breakdown is less fine. As expected, the counties vary greatly in their respective shares of the 0-19 age group, the more populous counties naturally having a larger share. The 0-19 age group makes up 33.5 percent of the total population of the province. Within each finer age group (0-4, 5-9 etc.) the number of males and females is almost identical.

Table 2 ranks the counties by their share of the province's 0-19 population for 1971, 1976, and 1981. We see that the differences, in spite of an overall decline, are relatively minor. The rank of most counties has stayed approximately the same while the actual number of people between the ages of 0-19 has dropped from a high of 320,965 in 1971 to 284,240 in 1981.

Table 3 attempts to give a bit of time perspective to the discussion of the proportion of the population in the 0-19 age group. That table compares the population for the three census years of 1971, 1976, and 1981. We see here a continuing decline in the representation of the 0-19 age group. Population projections are always somewhat risky, particularly during periods of economic uncertainty, but it seems probable that the 0-19 age group will continue to decline for some years to come as a proportion of our overall provincial population. Much publicity in recent years has been given the subject of school closings,as the number of school age children has decreased. In this Study, we are talking about providing mental health services for a slightly diminishing rather than increasing share of our population. We have moved, in Nova Scotia, from 0-19 = 40.7 percent in 1971, to 37.5 percent in 1976, to 33.5 percent in 1981.

Because the 0-19 age group is diminishing as a proportion of our general population does not mean that this Study must automatically re-

TABLE 1: NOVA SCOTIA'S POPULATION BY AGE AND SEX, BY COUNTY, 1981.[1]

	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19	20+	Total
Annapolis	1440	1550	1840	2310	7250	15,275	22,525
Male	720	860	950	1225	3755	7485	11,240
Female	720	800	890	1085	3495	7730	11,285
Antigonish							
Male	1710	1770	1840	1990	7310	10,795	18,105
Female	890	915	945	1005	3755	5270	9025
Cape Breton	9190	10,425	11,570	14,280	45,465	81,570	127,035
Male	4610	5390	6050	7205	23,255	39,315	62,570
Female	4580	5035	5520	7075	22,210	42,255	64,465
Colchester	2930	3405	3680	4355	14,370	28,855	43,225
Male	1505	1675	1875	2210	8265	14,030	21,295
Female	1425	1730	1805	2145	7105	14,825	21,930
Cumberland	2195	2515	2935	3530	11,175.	24,055	35,230
Male	1115	1320	1510	1895	5840	11,740	17,580
Female	1080	1195	1425	1635	5335	12,315	17,650
Digby	1345	1555	1950	2305	7155	14,530	21,685
Male	665	795	1045	1190	3695	7140	10,835
Female	680	760	905	1115	3460	7390	10,850
Guysborough	925	1080	1275	1410	4690	8060	12,750
Male	455	575	640	730	2400	4070	6470
Female	470	505	635	680	2290	3990	6280
Halifax	20,380	21,300	22,660	27,960	92,240	195,890	288,130
Male	10,445	10,935	11,545	14,385	47,310	93,955	141,265
Female	9935	10.365	11,055	13,575	44,930	101,935	146,865
Hants	2420	2890	3030	3395	11,735	21,385	33,120
Male	1230	1475	1540	1765	6010	10,525	16,535
Female	1190	1415	1490	1630	5725	10,860	16,585
Inverness	1815	1995	2230	2335	8375	13,960	22,335
Male	920	1025	1125	1200	4270	7055	11,325
Female	895	970	1105	1135	4105	6905	11,010
Kings	3655	3840	4275	5065	16,835	32,905	49,740
Male	1960	1975	2180	2570	8585	16,015	24,600
Female	1795	1865	2095	2495	8250	16,890	25,140

Table 1 (cont.)

	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19	20+	Total
Lunenburg	3025	3255	3560	4085	13,925	31,825	45,750
Male	1520	1685	1860	2075	7140	15,830	22,970
Female	1505	1570	1700	2010	6785	15,995	22,780
Pictou	3980	4270	4365	4825	17,440	32,905	50,345
Male	2035	2205	2230	2420	8890	16,145	25,035
Female	1945	2065	2135	2405	8550	16,760	25,310
Queens	795	960	1105	1255	4115	9015	13,130
Male	405	490	570	705	2170	4475	6645
Female	390	470	535	550	1945	4540	6485
Richmond	930	1105	1275	1360	4670	7615	12,285
Male	480	560	650	680	2370	3830	6200
Female	450	545	625	680	2300	3785	6085
Shelburne	1305	1390	1480	1730	5905	11,420	17,325
Male	680	740	760	895	3075	5720	8795
Female	625	650	720	835	2830	5700	8530
Victoria	645	655	710	895	2905	5525	8430
Male	315	340	375	470	1500	2790	4290
Female	330	315	335	425	1405	2735	4140
Yarmouth	1845	1955	2210	2670	8680	17,610	26,290
Male	910	1015	1170	1345	4440	8460	12,900
Female	935	940	1040	1325	4240	9150	13,390
Province	60,525	66,035	71,930	85,750	284,240	563,200	847,440
Male	30,760	33,975	37,005	43,965	145,705	273,870	419,575
Female	29,765	32,060	34,925	41,785	138,535	289,330	427,865
% of Total Population	7.1%	7.8%	8.5%	10.1%	33.5%	66.5%	100.0%

1. Source: Statistics Canada, 1981 census.

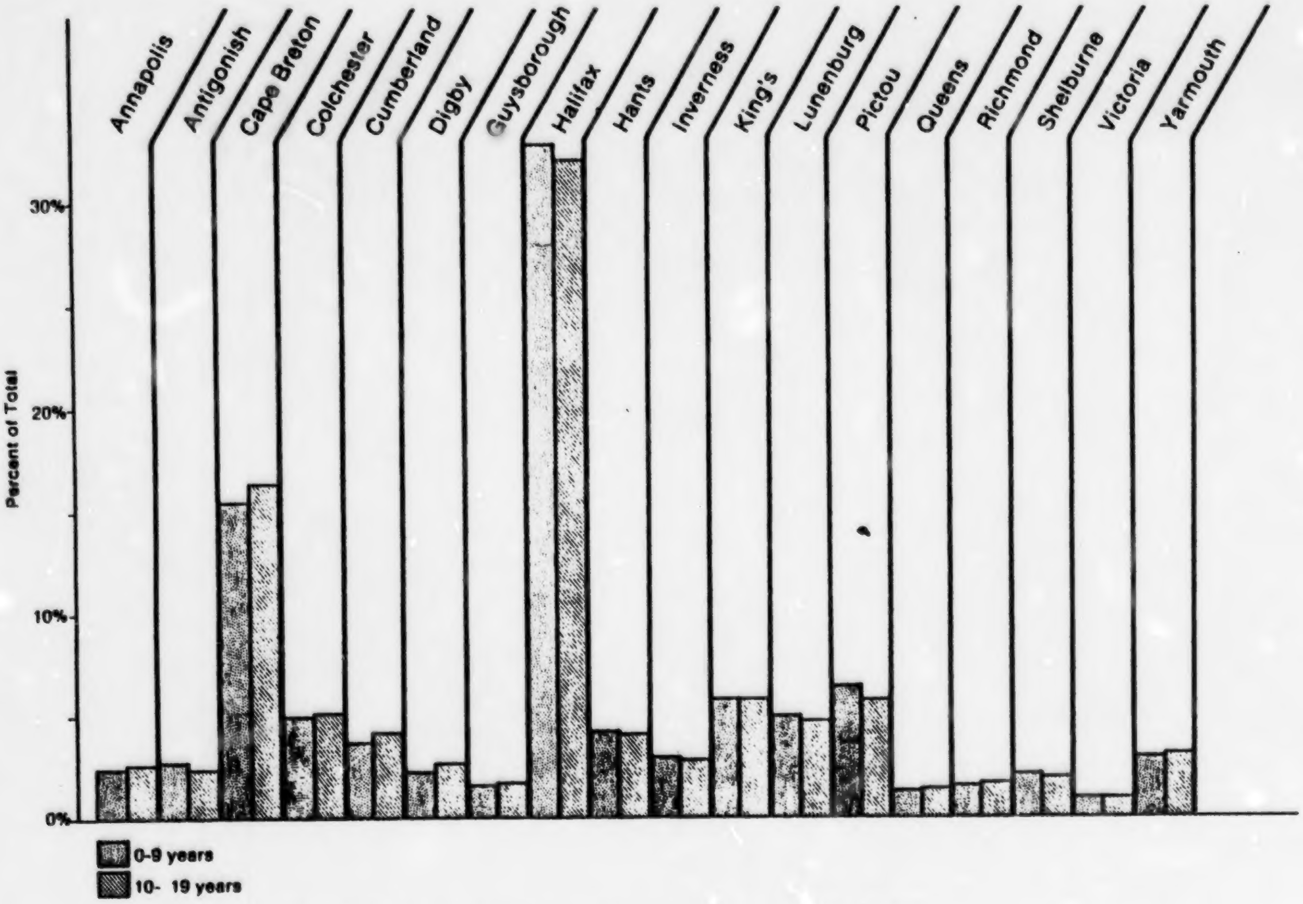

Figure 1. Percentage of each county's share of the 0-9 and 10-19 age groups in 1981.

TABLE 2: RANKING OF COUNTIES BY THEIR PERCENTAGE OF THE PROVINCIAL 0-19 AGE POPULATION FOR 1971,[1] 1976,[2] and 1981.[3,4]

	1971		1976		1981	
COUNTY	Population	Rank[5]	Population	Rank	Population	Rank
Annapolis	(2.7) 8590	10.5	(2.8) (8615)	11	(2.6) 7250	11.5
Antigonish	(2.4) 7745	13	(2.5) 7615	12.5	(2.6) 7310	11.5
Cape Breton	(17.6) 56,425	2	(16.5) 51,175	2	(16.0) 45,465	2
Colchester	(4.7) 15,025	5	(5.0) 15,530	5	(5.1) 14,370	5
Cumberland	(4.2) 13,395	7	(4.1) 12,600	8	(3.9) 11,175	8
Digby	(2.6) 8195	12	(2.5) 7745	12.5	(2.5) 7155	13
Guysborough	(1.7) 5475	16	(1.7) 5125	15.5	(1.7) 4690	15
Halifax	(32.5) 104,185	1	(32.5) 100,955	1	(32.5) 92,240	1
Hants	(3.8) 12,245	8	(4.2) 12,945	7	(4.1) 11,735	7
Inverness	(2.7) 8820	10.5	(2.9) 8860	9.5	(2.9) 8375	10
Kings	(5.8) 18,720	3	(5.9) 18,380	3.5	(5.9) 16,835	4
Lunenburg	(4.3) 13,685	6	(4.5) 14,085	6	(4.9) 13,925	6
Pictou	(5.7) 18,330	4	(5.9) 18,310	3.5	(6.1) 17,440	3
Queens	(1.5) 4815	17	(1.5) 4560	17	(1.4) 4115	17

TABLE 2: RANKING OF COUNTIES BY THEIR PERCENTAGE OF THE PROVINCIAL 0-19 AGE POPULATION FOR 1971,[1] 1976,[2] and 1981.[3,4]

	1971		1976		1981	
COUNTY	Population	Rank[5]	Population	Rank	Population	Rank
Richmond	(1.8) 5720	15	(1.7) 5230	15.5	(1.6) 4670	16
Shelburne	(2.1) 6840	14	(2.1) 6485	14	(2.1) 5905	14
Victoria	(1.0) 3175	18	(1.0) 3145	18	(1.0) 2905	18
Yarmouth	(3.0) 9600	9	(2.9) 9075	9.5	(3.1) 8680	9
Entire Province	(100.1) 320,985		(100.2) 310,435		(100.0) 284,240	

1. Statistics Canada, Census 1971. Population: General Characteristics. Vol. I, Part II. Catalogue # 92-715. (Ottawa: 1971), p. 9-1--9-4.
2. Statistics Canada, Supplementary Bulletins: Geographic and Demographic. Vol. 8, Catalogue # 92-835. (Ottawa: May, 1978), p. 1, 2, 19--24.
3. 1981 Census figures were provided by Statistics Canada.
4. Numbers in brackets are percentages of column totals.
5. If two counties are tied in their proportion of the provincial 0-19 population, the average ranking is assigned to each.

TABLE 3: POPULATION FIGURES AND PERCENTAGES BY AGE GROUP FOR NOVA SCOTIA, 1971[1], 1976[2], AND 1981[3,4]

AGE GROUP	1971	1976	1981
0 - 4	(8.8) 69,675	(7.9) 65,680	(7.1) 60,525
5 - 9	(10.8) 85,215	(8.7) 71,775	(7.8) 66,935
10 - 14	(10.9) 85,875	(10.4) 86,285	(8.5) 71,930
15 - 19	(10.2) 80,200	(10.5) 86,710	(10.1) 85,750
0 - 19	(40.7) 320,965	(37.5) 310,450	(33.5) [illegible]4,240
20+	(59.3) 467,995	(62.5) 518,120	(66.5) 563,200
Total	(100.0) 788,960	(100.0) 828,570	(100.0) 847,440

1. Statistics Canada, Census 1971. Population: General Characteristics. Vol.I, Part II. Catalogue #92-175. (Ottawa 1971), p. 9-1—9-4.

2. Statistics Canada, Supplementary Bulletins: Geographic and Demographic. Vol. 8. Catalogue #92-835 (Ottawa - May, 1978), p. 1,2, 19—24.

3. 1981 Census figures were provided by Statistics Canada.

4. Numbers in brackets are percentages of column totals.

5. For each year, males = 51%, females = 49% of the 0-19 age group.

commend that services be correspondingly reduced. Regardless of whether in 1990 the 0-19 age group consists of 29 or 32 or whatever percentage of the provincial population, it will nevertheless constitute all the children we have. A reduction in services would be indicated only if this Study found current services already to be fully adequate for the present population. Unfortunately, this is not the case.

The Outpatient Population

Table 4 compares counties for the census years of 1976 and 1981 in terms of the per thousand population rate of psychiatric outpatients for the 0-19 age group. In all cases, "county" is county-of-residence of the outpatient. We see overall an increase in 62 percent in use of outpatient facilities by this age group when population is held constant. Unfortunately, 1976 marked the inception of the Department of Health's current information-processing system. It is possible that some of the low usage shown for 1976 was due to early problems with that system. Thus, the spectacular gains shown by some counties (Richmond, Inverness, Digby) may or may not be real — at this late date, there is no way to be certain. What is clear, however, is that as of 1981 there were sharp differences among Nova Scotia's counties in the rate at which young people used outpatient mental health services. The highest rates are 15.8 per thousand 0-19 year olds in Kings County, followed by Halifax and Lunenburg counties each with rates of 14.4 per thousand. The lowest rates belong to Victoria County with 2.1 per thousand and Cape Breton County with 4.9 per thousand.

Assuming for the moment that mental health facilities are equally needed by young people in all counties, these discrepancies suggest a serious problem of inequity. As the social indicator data of appendix iii implies, the most likely explanation for this discrepancy in usage of outpatient mental health facilities by young people is the location and availability of these facilities.

TABLE 4: NUMBER OF AGE 0-19 PSYCHIATRIC OUTPATIENTS PER THOUSAND POPULATION FOR 1976 AND 1981, FOR NOVA SCOTIA.[1,2]

	1976	1981	% INCREASE
Annapolis County	3.3	11.0	233
Antigonish County	2.9	9.6	231
Cape Breton County	3.2	4.9	53
Colchester County	5.5	8.8	60
Cumberland County	7.0	10.2	46
Digby County	1.7	8.0	371
Guysborough County	2.9	11.7	303
Halifax County	9.1	14.5	59
Hants County	5.7	8.7	53
Inverness County	1.6	8.1	406
Kings County	12.7	15.8	24
Lunenburg County	9.3	14.5	56
Pictou County	10.4	11.0	6
Queens County	7.5	11.2	49
Richmond County	2.1	10.7	410
Shelburne County	3.5	8.8	151
Victoria County	1.3	2.1	62
Yarmouth County	5.4	11.3	109
Nova Scotia	6.8	11.0	62

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1. These years are compared because they are census years for which accurate demographic data are available.

2. 1976 marked the inception of the Department of Health's computer system and the difference *may* be due to early problems with that system.

Table 5 breaks down the previous table's 1981 data in a more detailed manner, giving both age group and sex. Other tables will analyze further what is immediately apparent: the 0-4 age group is heavily under-represented throughout the Province and the 5-9 group only somewhat less so. For the Province as a whole, males are more likely than females to use mental health facilities as outpatients, though this is not true of all counties (Yarmouth, Lunenburg, Queens, Victoria). The contrast between some counties can be extreme, e.g., Pictou County has 15.1 male and 6.7 female outpatients per thousand individuals in the 0-19 group, while Queens has 10.1 males and 12.3 female outpatients per thousand members of that age group. Presumably, such differences reflect staffing and reputation (which influences referrals) of the outpatient mental health facility or facilities serving each county.

Figure 2 is a bar graph showing the number of psychiatric outpatients for Nova Scotia by age group and sex for the 0-19 children and adolescents, for 1981. For females, the use of outpatient mental health facilties increases in almost linear fashion from birth through age 19. For males the use of facilities peaks at 10-14 and then declines. Only for the 15-19 age group do males fail to use facilities more than do females. The fact that there are not necessarily the same number of children in each age group in the general population introduces some distortion into the figure, however.

Figure 3 corrects any distortion by calculating usage on the basis of number of outpatients per thousand population for each age/sex category. Even holding population constant in this manner, however, male usage of outpatient mental health facilities still peaks at age 10-14 and subsequently declines. Through age 0-19 males use outpatient mental health facilities more often than do females, for the over nineteen outpatients this relationship is reversed.

Table 8: OUTPATIENTS PER THOUSAND POPULATION, BY AGE GROUP AND SEX, FOR EACH COUNTY, 1981[1]

	Annapolis County			Antigonish County			Cape Breton County			Colchester County			Cumberland County		
AGE GROUP	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
0 - 4	-	2.8	1.4	2.2	4.9	3.5	1.1	0.9	1.0	5.3	1.4	3.4	1.8	1.9	1.8
5 - 9	3.5	-	1.8	10.9	3.5	7.3	8.0	3.5	5.8	7.2	6.4	6.8	12.9	6.7	9.9
10 - 14	22.1	11.2	16.8	13.8	10.1	12.0	6.4	4.2	5.4	11.7	5.5	8.7	21.9	11.2	16.7
15 - 19	21.2	16.6	19.0	11.9	17.3	14.6	7.5	5.4	6.4	12.2	15.9	14.0	4.7	16.5	10.2
0 - 19	13.3	8.6	11.0	9.9	9.3	9.6	6.1	3.6	4.9	9.5	8.0	8.8	10.4	9.9	10.2
20 +	11.0	14.5	12.8	9.7	15.9	12.9	7.2	7.7	7.5	4.9	9.2	7.1	12.0	18.0	15.1
TOTAL	11.7	12.7	12.2	9.8	13.3	11.5	6.8	6.3	6.5	6.5	8.8	7.7	11.5	15.6	13.5

Table 5 (cont.)

	Digby County			Guysborough County			Halifax County			Hants County			Inverness County		
AGE GROUP	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
0 - 4	3.0	1.5	2.2	6.6	3.1	4.3	7.8	5.2	6.5	4.1	0.8	2.5	2.2	4.5	3.3
5 - 9	7.5	3.9	5.8	7.0	13.9	10.2	21.2	12.0	16.7	10.8	7.1	9.0	20.5	3.1	12.0
10 - 14	14.4	8.8	11.8	15.6	4.7	10.2	22.1	16.5	19.3	18.8	6.0	12.5	10.7	8.1	9.4
15 - 19	9.2	9.9	9.5	21.9	16.2	19.1	14.2	15.0	14.6	9.6	9.2	9.4	7.5	7.0	7.3
0 - 19	9.2	6.6	8.0	13.8	9.6	11.7	16.3	12.5	14.5	11.1	6.1	8.7	10.3	5.8	8.1
20 +	12.3	16.0	14.2	7.1	12.8	9.9	6.1	6.7	6.4	5.3	5.7	5.5	7.9	11.0	9.5
TOTAL	11.3	13.0	12.1	9.6	11.6	10.6	9.5	8.5	9.0	7.4	5.8	6.6	8.8	9.1	9.0

Table 5 (cont.)

	King's County			Lunenburg County			Pictou County			Queens County			Richmond County		
AGE GROUP	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
0 - 4	3.2	-	1.6	5.9	4.0	5.0	3.4	0.5	2.0	2.5	-	1.3	-	-	-
5 - 9	14.7	12.3	13.5	19.0	12.1	15.7	18.6	7.7	13.3	8.2	8.5	8.3	19.6	5.5	12.7
10 - 14	29.4	14.3	22.0	12.9	12.4	12.6	23.8	7.5	15.8	10.5	18.7	14.5	18.5	16.0	17.3
15 - 19	15.6	29.7	22.5	14.9	29.9	22.3	13.6	10.0	11.8	15.6	18.2	16.7	13.2	7.4	10.3
0 - 19	16.2	15.4	15.8	13.4	15.6	14.5	15.1	6.7	11.0	10.1	12.3	11.2	13.5	7.8	10.7
20 +	12.4	18.2	15.4	8.9	14.1	11.5	4.1	8.0	6.1	7.8	12.6	10.2	6.3	9.5	7.9
TOTAL	13.7	17.3	15.5	10.3	14.6	12.4	8.0	7.5	7.8	8.6	12.5	10.5	9.0	8.9	9.0

Table 5 (cont.)

	Shelburne County			Victoria County			Yarmouth County			Row Totals		
AGE GROUP	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
0 - 4	1.5	4.8	3.1	-	-	-	-	1.1	0.5	4.4	2.8	3.6
5 - 9	10.8	-	5.8	-	2.9	1.5	11.8	6.4	9.2	14.7	8.0	11.5
10 - 14	11.8	5.6	8.8	8.0	6.0	7.0	15.4	16.3	15.8	17.2	11.1	14.3
15 - 19	25.7	4.8	15.6	-	-	-	11.9	21.1	16.5	12.5	14.0	13.2
0 - 19	13.3	3.9	8.8	2.0	2.1	2.1	10.4	12.3	11.3	12.5	9.5	11.0
20 +	4.9	9.1	7.0	3.6	4.4	4.0	12.9	18.9	16.0	7.5	9.9	8.7
TOTAL	7.8	7.4	7.6	3.0	3.6	3.3	12.0	16.8	14.5	9.2	9.8	9.5

Figure 2. Number of Mental Health Outpatients for Nova Scotia (1981)

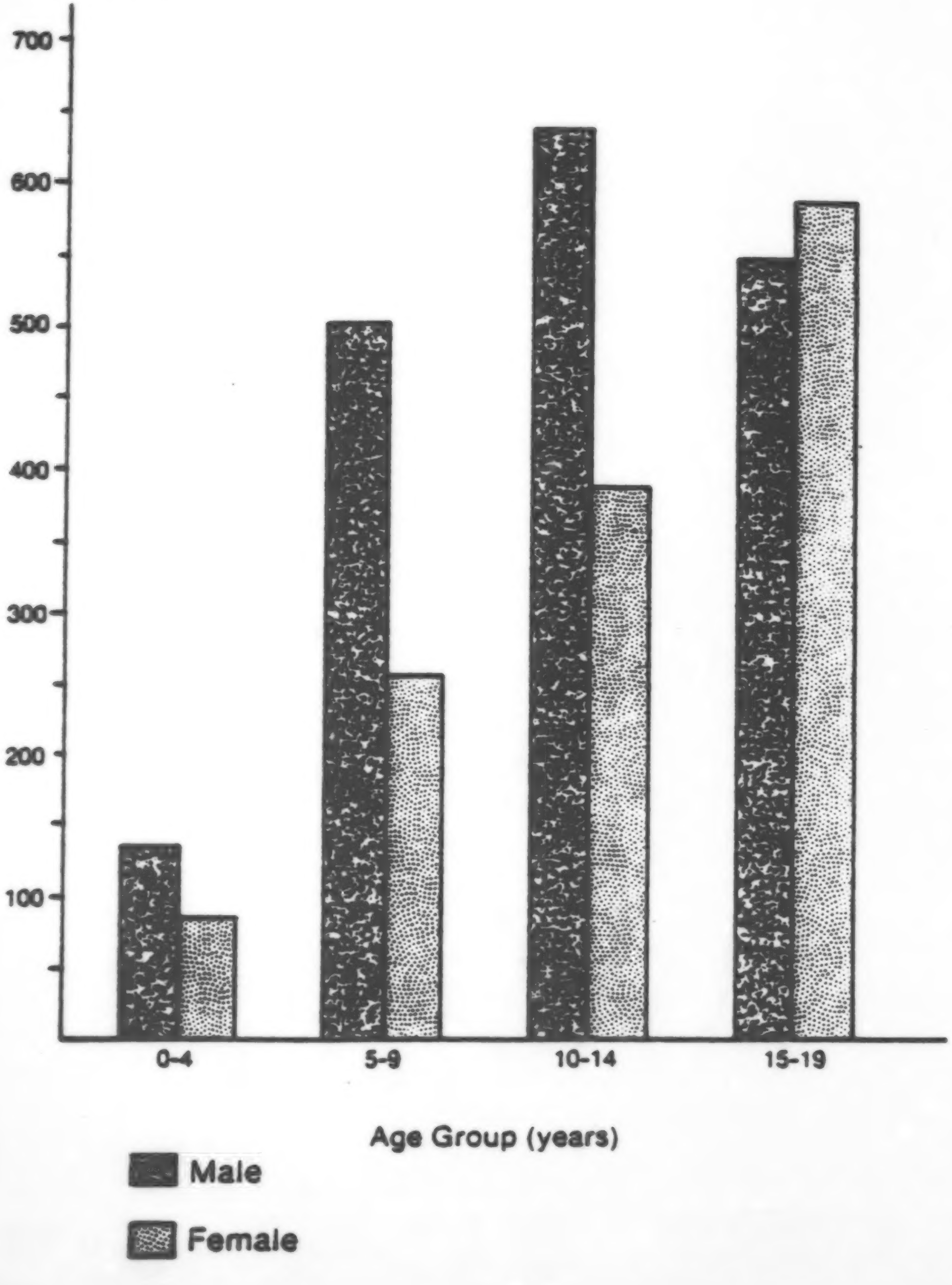


Figure 3. Mental Health Outpatients Per Thousand Population by Age Group and Sex for Nova Scotia, 1981.

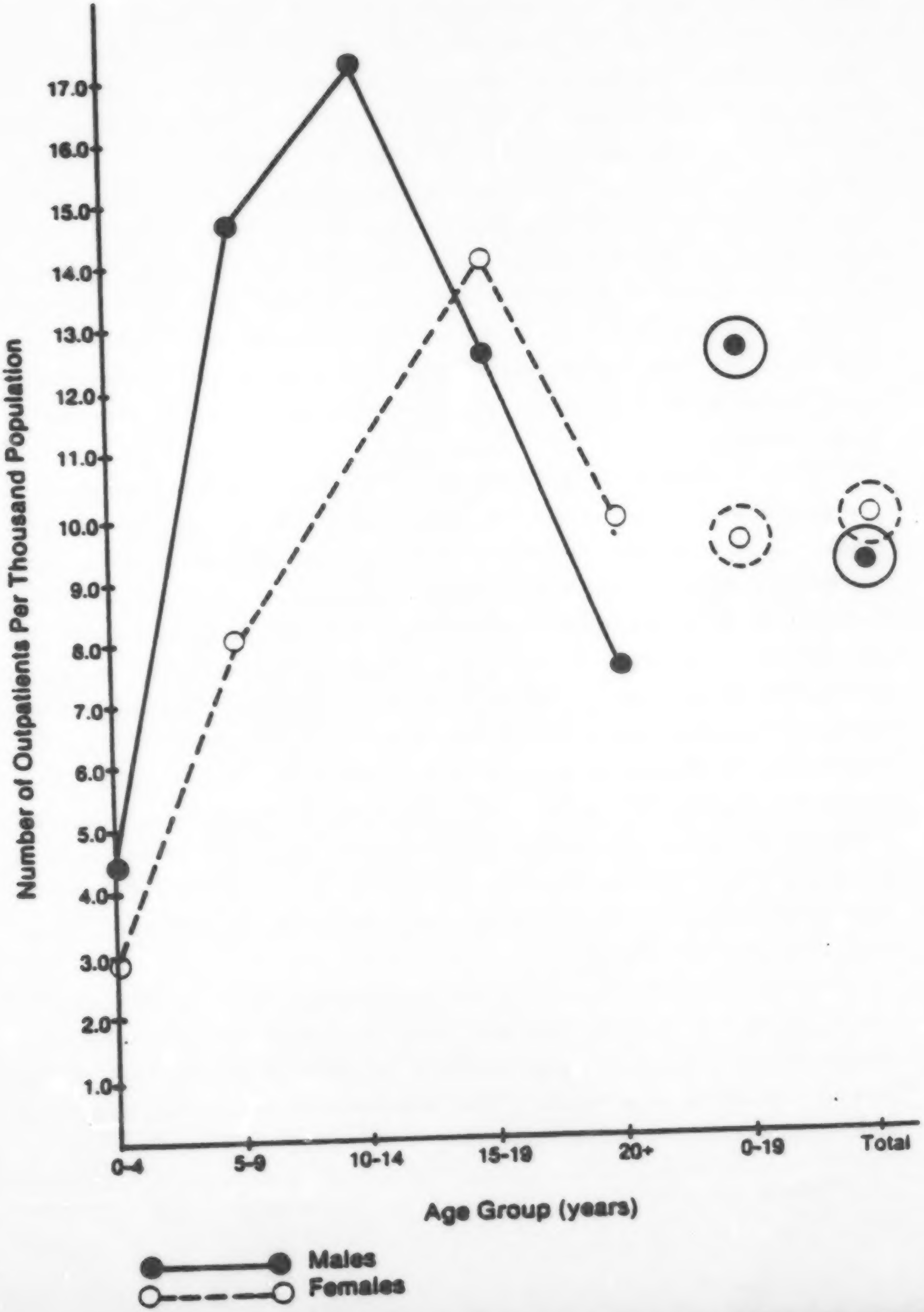


Figure 4 compares the number of 0-19 psychiatric outpatients in 1981 for Nova Scotia with comparable data from Saskatchewan. For the latter province, the data are from 1978 and include only the 0-17 age range. Table 6 presents the same data in numerical form. Ignoring the two points of difference in the tables, however, both provinces show precisely the same number of outpatients per thousand. In otherprovinces, too, males use outpatient mental health services considerably more frequently than do females. Nova Scotia falls somewhat below Saskatchewan in female outpatients in the 5-9 group but seems to make up for this by having more female outpatients in the 10-14 age group. In general, assuming that 1981 Saskatchewan data would not differ sharply from 1978 data, the two provinces appear to be quite similar overall in their patterns of utilization of outpatient mental health services by young people.

Table 7 takes us to a discussion of the relative representation of age groups within the outpatient population. If all age groups were equally likely to use outpatient mental health facilities then their representation in the outpatient population would directly reflect their representation in the general population. Table 7 suggests this is not so. We find, for example, that even though the 0-4 age group makes up 7.1 percent of the provincial population, it makes up only 3.1 percent of the psychiatric outpatient population. Clearly, 0-4 year olds are unlikely to be brought to a mental health facility. This finding is not altogether surprising, given that many behavioural problems may not manifest themselves unambiguously until school age. But in the opinion of mental health professionals consulted lack of treatment for 0-4 year olds represents a serious problem, one which will be discussed at the conclusion of this chapter.

If the 0-4 year olds are under-represented, children (and adolescents) above the age of four are over-represented in the outpatient mental health population (when compared to their representation in the general population as a whole). This over-representation out-weighs the under-presentation of young children:

TABLE 6

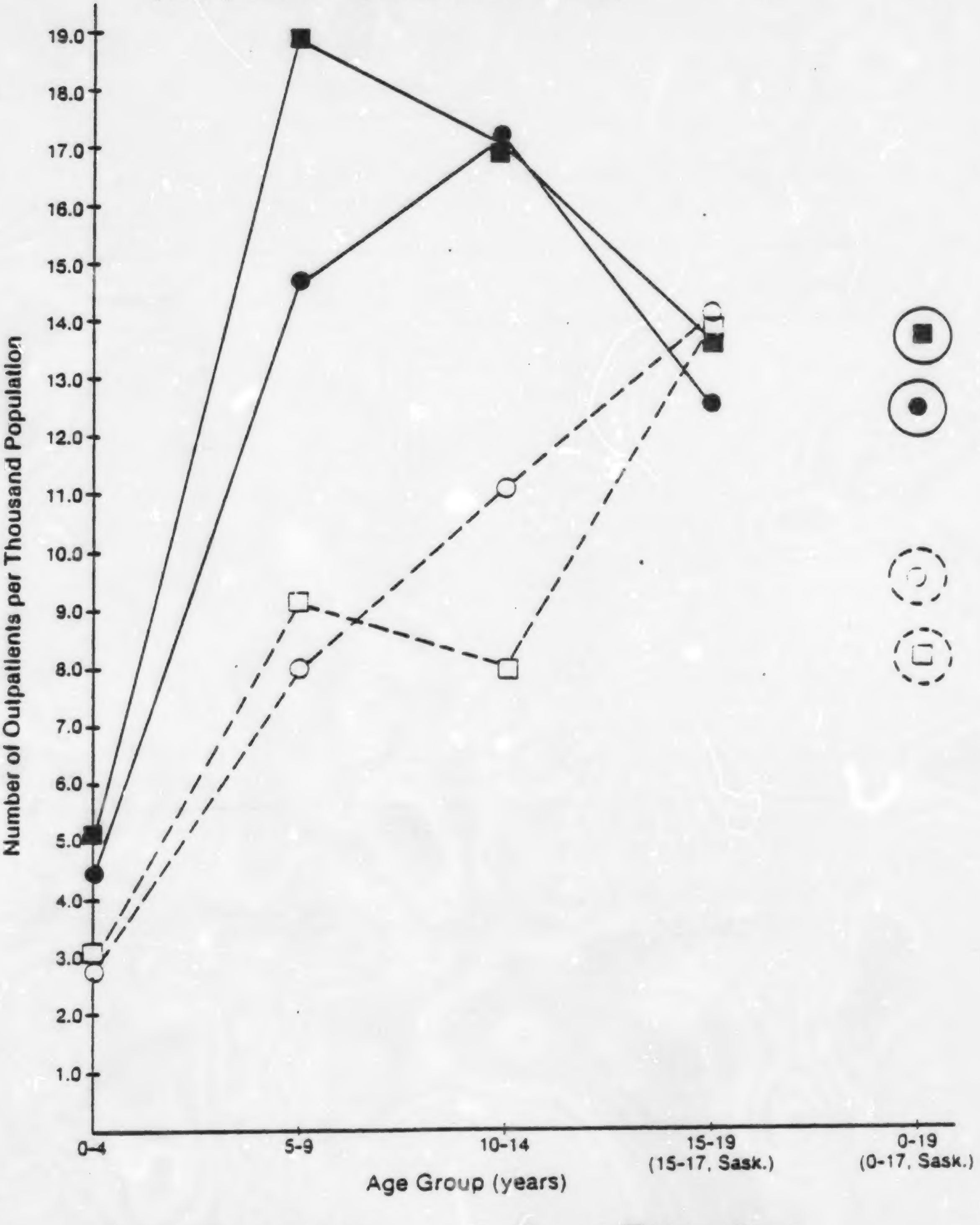
MENTAL HEALTH OUTPATIENTS PER THOUSAND POPULATION BY AGE GROUP AND SEX FOR NOVA SCOTIA (1981) AND FOR SASKATCHEWAN (1978) [1,2]

AGE GROUP	SEX	(1981) NOVA SCOTIA	(1978) SASKATCHEWAN
0 - 4	Both	3.6	4.0
	Male	4.4	5.1
	Female	2.8	2.9
5 - 9	Both	11.5	14.1
	Male	14.7	18.8
	Female	8.0	9.2
10 - 14	Both	14.3	12.6
	Male	17.2	17.0
	Female	11.1	8.0
15 - 19 (15-17 Sask)	Both	13.2	13.7
	Male	12.5	13.7
	Female	14.0	13.8
0 - 19 (0-17 Sask)	Both	11.0	11.0
	Male	12.5	13.7
	Female	9.5	8.2

1. Population figures for Nova Scotia from the 1981 Census were provided by Statistics Canada.

2. Saskatchewan data were obtained from Current Health Resources, Organization and Utilization, Saskatchewan Health, 1980. Table 3.4, page 85.

Figure 4. Comparison of Number of Mental Health Outpatients Per Thousand Population for Nova Scotia (1981) and for Saskatchewan (1978).



1. Based on Table 6; and Table 3.4 in *Current Health Resources; Organization and Utilization;* (Saskatchewan Health, 1980) p. 85.

TABLE 7:

COMPARISON OF REPRESENTATION OF AGE GROUPS IN GENERAL POPULATION WITH THEIR REPRESENTATION IN OUTPATIENT POPULATION, FOR NOVA SCOTIA, 1981.

	AGE GROUPS						
	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19	20+	Total
Percentage of total outpatient registrations	3.1	9.7	13.2	13.2	39.3	60.7	100.0
Percentage of provincial population[1]	7.1	7.8	8.5	10.1	33.5	66.5	100.0

[1] Percentages of Nova Scotia Population were derived from 1981 Census figures, provided by Statistics Canada.

as a rasult, the 0-19 age group as a whole is over-represented, making up 39.3 percent of the outpatient population but only 33.5 percent of the provincial population. ("Over-represented" here means in comparison with representation in the general population rather than in comparison with the share of services some may feel they should be receiving.)

Table 8 takes the total province data presented in the previous table and breaks it down by county. It also differs from the previous table in that it refers to outpatient registrations (individuals registered as outpatients in 1981) as opposed to outpatients per se (that is, individuals who were outpatients in 1981 regardless of when they were registered). This difference, however, is quite minor. More important is the fact that table 8 not only compares each age group's representation in the mental health outpatient population of each county, it also compares the actual number of outpatients with the number we would expect on the basis of each age group's demographic representation.

Once again, we see major variation from county-to-county and from age group to age group. Not only is the 0-4 group once again under-represented, in some counties (Victoria and Richmond) it is missing entirely! For the 5-9 age group, variation across counties is especially striking. For example, Halifax County's actual outpatient registrations for this group were 185 percent of expected registrations, while Annapolis County had only 15 percent of its expected 5-9 registrants. Variation is similar for the 10-14 group, with Halifax County enjoying actual registrations of 216 percent of expected, Hants County 190 percent of expected, but Cape Breton only 82 percent of expected registrations. For 15-19 year olds, Halifax County's adolescents are once again well-served, but this time so are those of many other counties. Clearly, the various outpatient mental health facilities should examine the data from those counties they serve and analyze the problems which lead to their underserving particular age groups. Clearly, too, children and adolescents from Halifax County are the best served in the Province in terms of access to mental health facilities.

TABLE 8: EXPECTED AND ACTUAL AGE DISTRIBUTION OF MENTAL HEALTH OUTPATIENT REGISTRATIONS, FOR EACH COUNTY, 1981.[1]

		Annapolis Co.		Antigonish Co.		Cape Breton Co.		Colchester Co.		Cumberland Co.		Digby Co.		Guysborough Co.	
AGE GROUP		# OF PATIENTS	%	# OF PATIENTS	%	# OF PATIENTS	%	# OF PATIENTS	%	# OF PATIENTS	%	# OF PATIENTS	%	# OF PATIENTS	%
	actual	2	0.7	7	2.9	9	1.1	10	3.0	4	0.8	3	1.1	4	3.0
0 - 4	expected	18	6.4	20	9.4	60	7.2	23	6.8	30	6.2	16	6.2	10	7.3
	actual	3	1.1	13	6.2	59	7.1	23	6.9	25	5.2	9	3.4	11	8.1
5 - 9	expected	20	7.4	20	9.8	68	8.2	26	7.9	34	7.1	19	7.2	11	8.5
	actual	31	11.3	22	10.5	62	7.5	32	9.7	49	10.3	23	8.7	13	9.6
10-14	expected	23	8.2	21	10.2	76	9.1	28	8.5	40	8.3	24	9.0	14	10.0
	actual	44	16.0	29	13.9	92	11.1	61	18.4	36	7.5	22	8.4	27	20.0
15 - 19	expected	28	10.3	23	11.0	93	11.2	33	10.1	48	10.0	28	10.6	15	11.1
	actual	80	29.1	70	33.5	222	26.7	126	38.1	114	23.9	57	21.7	55	40.7
0-19	expected	89	32.2	84	40.4	297	35.8	110	33.2	151	31.7	87	33.0	50	36.8
	actual	195	70.9	139	66.5	608	73.3	205	61.9	363	76.1	206	78.3	80	59.3
20+	expected	186	67.8	125	59.6	533	64.2	221	66.8	326	68.2	176	67.0	85	63.2
	actual	275	100.0	209	100.0	830	100.0	331	100.0	477	100.0	263	100.0	135	100.0
Total	expected	275	100.0	209	100.0	930	100.0	331	100.0	477	100.0	263	100.0	135	100.0

Table 8 (cont.)

AGE GROUP		Halifax Co # OF PATIENTS	Halifax Co %	Hants Co. # OF PATIENTS	Hants Co. %	Inverness Co. # OF PATIENTS	Inverness Co. %	Kings Co. # OF PATIENTS	Kings Co. %	Lunenburg Co. # OF PATIENTS	Lunenburg Co. %	Pictou Co. # OF PATIENTS	Pictou Co. %	Queens Co. # OF PATIENTS	Queens Co. %
	actual	133	5.1	6	2.7	6	3.0	6	0.8	15	2.6	8	2.0	1	0.7
0 - 4	expected	184	7.1	16	7.3	16	8.1	56	7.3	38	6.6	31	7.9	8	6.1
	actual	356	13.7	26	11.8	24	12.0	52	6.7	51	9.0	57	14.6	8	5.8
5 - 9	expected	192	7.4	19	8.7	18	8.9	60	7.7	40	7.1	33	8.5	10	7.3
	actual	437	16.8	38	17.3	21	10.5	94	12.2	45	7.9	69	17.6	16	11.6
10-14	expected	202	7.8	20	9.1	20	10.0	66	8.6	44	7.8	34	8.7	12	8.4
	actual	407	15.7	32	14.5	17	8.5	114	14.7	91	16.0	57	14.6	21	15.4
15 - 19	expected	252	9.7	23	10.3	21	10.5	79	10.2	51	8.9	38	9.6	13	9.6
	actual	1333	51.4	102	46.4	68	34.0	266	34.4	202	35.5	191	48.8	46	33.3
0-19	expected	830	32.0	78	35.4	75	37.5	261	33.8	173	30.4	135	34.6	43	31.3
	actual	1261	48.6	118	53.6	132	66.0	507	65.6	367	64.5	200	51.2	92	66.7
20+	expected	1764	68.0	142	64.6	125	62.5	512	66.2	396	69.6	256	65.4	95	68.7
	actual	2594	100.0	220	100.0	200	100.0	773	100.0	569	100.0	391	100.0	138	100.0
Total	expected	2594	100.0	220	100.0	200	100.0	773	100.0	569	100.0	391	100.0	138	100.0

Table 8 (cont.)

AGE GROUP		Richmond Co. # OF PATIENTS	Richmond Co. %	Shelburne Co. # OF PATIENTS	Shelburne Co. %	Victoria Co. # OF PATIENTS	Victoria Co. %	Yarmouth Co. # OF PATIENTS	Yarmouth Co. %	Entire Province # OF PATIENTS	Entire Province %
0 - 4	actual	-	-	4	3.0	-	-	1	0.3	218	2.7
	expected	8	7.6	10	7.5	2	7.7	27	7.0	572	7.1
5 - 9	actual	14	12.7	8	6.1	1	3.6	18	4.7	758	9.4
	expected	10	9.0	11	8.0	2	7.8	28	7.4	628	7.8
10-14	actual	22	20.0	13	9.8	5	17.9	35	9.2	1027	12.7
	expected	11	10.4	11	8.5	2	8.4	32	8.4	685	8.5
15 - 19	actual	14	12.7	27	20.5	-	-	44	11.6	1135	14.1
	expected	12	11.1	13	10.0	3	10.6	39	10.2	814	10.1
0-19	actual	50	45.5	52	39.4	6	21.4	98	25.8	3138	39.0
	expected	42	38.0	45	34.1	10	34.5	125	33.0	2698	33.5
20+	actual	60	54.5	80	60.6	22	78.6	282	74.2	4917	61.0
	expected	68	62.0	87	65.9	18	65.5	255	67.0	5357	66.5
Total	actual	110	100.0	132	100.0	28	100.0	380	100.0	8055	100.0
	expected	110	100.0	132	100.0	28	100.0	380	100.0	8055	100.0

1. Population figures from the 1981 Census were provided by Statistics Canada.

2. The 'Expected' Number of Patients is rounded to the nearest integer and based on the proportion of the county population found in a given age group.

The Facilities Themselves

Tables 9 to 23 deal with specific mental health facilities. The names of the facilities have been deliberately omitted from these tables in order to avoid invidious comparisons of staff who work under stress and responsibility rarely appreciated by those of us not in the helping professions, and in order that no facility be victimized by possible imperfections in the data. As has already been noted, different facilities fill out forms in different ways. However, in order that mental health facilities be able to make use of those data which pertain to them, the Minister of Health may at his discretion provide each with its own code number.

Not all facilities appear in all tables. At least some data do appear, however, for each of the facilities listed below:

Cape Breton Hospital, Sydney
Bertha Churchill Clinic, Yarmouth Regional Hospital
Nova Scotia Hospital, Dartmouth
Fundy Mental Health Centre, Wolfville (now part of the Valley Hospital Association)
Atlantic Child Guidance Centre, Halifax-Dartmouth-Sackville
Izaak Walton Killam Hospital, Halifax
Abbie J. Lane Memorial Hospital, Halifax (now part of the Camp Hill Hospital Complex)
Mental Health Clinic, Dawson Memorial Hospital, Bridgewater
Department of Psychiatry, St. Martha's Hospital, Antigonish (formerly Eastern Counties Mental Health Centre)
Cobequid Mental Health Centre, Colchester Hospital, Truro
Pictou County Mental Health Centre, New Aberdeen Hospital, New Glasgow

Table 9 gives us the number and percentage of outpatients, by age group and sex, for eleven mental health facilities for 1981. Table 10 gives us similar data for outpatient registrations for nine facilities. Certain facilities have been omitted from each table because data were not available at the time the tables were prepared. Table 10 calculates the expected number of outpatient registrations on the basis of the population figures for the county in which each facility is located, so that facilities deriving a large proportion of their outpatients from outside their general region were not included. In the case of Table 9, all data from the omitted facilities are included in the final column, which therefore permits generalization about the Province's outpatient mental health services as a whole.

In general, the results of these tables are so close to those from the earlier county-by-county analysis that their inclusion is justified only by the hope that they will be of some interest to the actual directors and planners of the facilities themselves. Once gain, the tables show great variability in the proportion of outpatient registrations in the 0-19 age group. For example, facility 05 in Table 9 has only 15.4 percent of its total 1981 registrations in the 0-19 age group, while 31.6 percent of 1981 registrations of facility 06 are in this group. Similar variation occurs in terms of specific age groups within the 0-19 range, as when facility 12's 10-14 year olds account for only 6.0 percent of its outpatients, as opposed to 14.4 percent for facility 11. For all facilities, for most age groups, males outnumber females as outpatients. Table 10's "row totals" show that, as expected, without the specialized mental health facilities (excluded from this table) Nova Scotia's children and adolescents would be severely under-represented in the Province's psychiatric outpatient population. Thus, it is apparent that facilities specializing in children and adolescent mental health are justified.

Table 11 compares the staff involved in the initial assessment of outpatients for each mental health facility, for the 0-19 age group, for

TABLE 9; NUMBER AND PERCENTAGE OF OUTPATIENTS, BY AGE GROUP AND SEX, FOR ELEVEN MENTAL HEALTH FACILITIES, 1981.[1]

	(02)			(04)			(05)			(06)			(07)		
AGE GROUP	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
	(0.2)	(1.0)	(0.7)	(0.2)		(0.1)	(0.5)	(0.5)	(0.5)	(3.1)	(0.7)	(1.8)	(0.6)	(0.2)	(0.4)
0 - 4	1	6	7	1		1	4	4	8	7	2	9	2	1	3
	(7.2)	(1.5)	(3.9)	(1.2)	(0.4)	(0.7)	(6.1)	(2.1)	(4.0)	(7.6)	(4.1)	(5.7)	(7.2)	(1.3)	(3.8)
5 - 9	31	9	40	7	3	10	49	18	67	17	12	29	24	6	30
	(10.2)	(6.3)	(7.9)	(3.9)	(2.0)	(2.8)	(6.2)	(2.1)	(4.0)	(12.1)	(5.2)	(8.2)	(11.0)	(3.2)	(6.5)
10 - 14	44	38	82	23	15	38	50	18	68	27	15	42	37	15	52
	(13.2)	(7.8)	(10.0)	(13.4)	(8.8)	(10.8)	(9.0)	(4.9)	(6.9)	(16.6)	(15.5)	(16.0)	(6.0)	(7.1)	(6.6)
15 - 19	57	47	104	79	66	145	73	43	116	37	45	82	20	33	53
	(30.8)	(16.6)	(22.5)	(18.7)	(11.2)	(14.5)	(21.8)	(9.5)	(15.4)	(39.5)	(25.5)	(31.6)	(24.8)	(11.9)	(17.3)
0 - 19	133	100	233	110	84	194	176	83	259	88	74	162	83	55	138
	(69.2)	(83.4)	(77.5)	(81.3)	(88.8)	(85.5)	(78.2)	(90.5)	(84.6)	(60.5)	(74.5)	(68.4)	(75.2)	(88.1)	(82.7)
20 +	299	504	803	479	664	1143	632	791	1423	135	216	351	252	409	661
	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)
Total	432	604	1,036	589	748	1337	808	874	1682	223	290	513	336	464	799

TABLE 9 (cont.)

	(08)			(09)			(10)			(11)			(12)		
AGE GROUP	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
0 - 4	(0.8) 2	(0.3) 1	(0.5) 3	(1.5) 6	(1.8) 9	(1.6) 15	(1.0) 7	(0.4) 4	(0.7) 11	(2.7) 7	(0.3) 1	(1.4) 8	(2.4) 11	(0.8) 6	(1.4) 17
5 - 9	(2.4) 6	(0.6) 2	(1.4) 8	(11.7) 48	(3.3) 17	(7.0) 65	(5.7) 39	(3.1) 28	(4.2) 67	(19.2) 49	(6.6) 20	(12.4) 69	(8.8) 41	(3.6) 26	(5.7) 67
10 - 14	(13.4) 34	(4.5) 14	(8.5) 48	(14.7) 60	(6.2) 32	(10.0) 92	(12.2) 84	(4.4) 40	(7.8) 124	(25.1) 64	(5.3) 16	(14.4) 80	(7.9) 37	(4.7) 34	(6.0) 71
15 - 19	(14.2) 36	(10.5) 33	(12.1) 69	(10.3) 42	(8.8) 45	(9.4) 87	(8.7) 60	(9.8) 88	(9.3) 148	(14.5) 37	(10.6) 32	(12.4) 69	(11.3) 53	(10.1) 72	(10.6) 125
0 - 19	(30.7) 78	(15.9) 50	(22.5) 128	(38.1) 156	(20.1) 103	(28.1) 259	(27.7) 190	(17.8) 160	(22.1) 350	(61.6) 157	(22.9) 69	(40.6) 226	(30.3) 142	(19.3) 138	(23.6) 280
20 +	(69.3) 176	(84.1) 264	(77.5) 440	(61.9) 253	(79.9) 410	(71.9) 663	(72.3) 496	(82.2) 741	(77.9) 1237	(38.4) 98	(77.1) 232	(59.4) 330	(69.7) 326	(80.7) 578	(76.4) 904
Total	(100.0) 254	(100.0) 314	(100.0) 568	(100.0) 409	(100.0) 513	(100.0) 922	(100.0) 686	(100.0) 901	(100.0) 1587	(100.0) 255	(100.0) 301	(100.0) 556	(100.0) 468	(100.0) 716	(100.0) 1184

TABLE 9 (cont.)

	(13)			All Facilities Plus Excluded Facilities		
AGE GROUP	Male	Female	Both	Male	Female	Both
0 - 4	(11.2) 72	(11.8) 49	(11.4) 121	(2.4) 148	(1.3) 93	(1.8) 241
5 - 9	(34.1) 220	(28.6) 119	(32.0) 339	(10.2) 619	(4.2) 299	(7.0) 918
10 - 14	(36.1) 233	(36.1) 150	(36.1) 383	(13.2) 798	(6.7) 475	(9.7) 1273
15 - 19	(18.1) 117	(23.1) 96	(20.1) 213	(11.4) 691	(10.3) 732	(10.8) 1423
0 - 19	(99.5) 642	(99.6) 414	(99.6) 1056	(37.3) 2256	(22.5) 1599	(29.3) 3855
20 +	(0.5) 3	(0.6) 2	(0.5) 5	(62.7) 3791	(77.5) 5503	(70.7) 9294
TOTAL	(100.0) 645	(100.0) 416	(100.0) 1061	(100.0) 6047	(100.0) 7102	(100.0) 13149

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[1] Numbers in brackets are percentages of column totals.

Table 10: Expected and Actual Age Distribution of Outpatient Registrations for Nine Mental Health Facilities, 1981.[1]

AGE GROUP		02 Number of[2] Registrations	02 %[3]	05 Number of Registrations	05 %	06 Number of Registrations	06 %	07 Number of Registrations	07 %	08 Number of Registrations	08 %
0 - 4	Actual	7	1.2	10	1.1	11	3.1	3	0.6	5	1.1
	Expected	42	7.0	64	7.2	24	6.8	31	6.2	27	6.2
5 - 9	Actual	33	5.5	63	7.1	25	7.1	25	5.0	10	2.3
	Expected	44	7.4	73	8.2	28	7.9	35	7.1	31	7.2
10 - 14	Actual	60	10.1	49	5.5	41	11.6	44	8.9	48	11.0
	Expected	50	8.4	81	9.1	30	8.5	41	8.3	39	9.0
15 - 19	Actual	71	11.9	94	10.5	65	18.4	37	7.5	60	13.8
	Expected	61	10.2	100	11.2	36	10.1	50	10.0	46	10.6
0 - 19	Actual	171	28.7	216	24.2	142	40.1	109	22.0	123	28.2
	Expected	196	33.0	320	35.8	118	33.2	157	31.7	144	33.0
20+	Actual	424	71.3	677	75.8	212	59.9	387	78.0	313	71.8
	Expected	399	67.0	573	64.2	236	66.8	339	68.3	292	67.0
TOTAL	Actual	595	100.0	893	100.0	354	100.0	496	100.0	436	100.0
	Expected	595	100.0	893	100.0	354	100.0	496	100.0	436	100.0

TABLE 10 (cont.)

AGE GROUP		09		10		11		12		Row Totals	
		Number of Registrations	%	Number of Registrations	%	Number of Registrations	%	Number of Registrations	%	Number of Registrations	%[4]
0 - 4	Actual	19	3.0	9	1.0	13	3.6	20	2.7	97	1.8
	Expected	59	9.4	63	7.3	28	7.9	49	6.6	381	7.1
5 - 9	Actual	62	9.9	69	8.0	53	14.7	53	7.2	393	7.3
	Expected	62	9.8	67	7.7	31	8.5	53	7.1	419	7.8
10 - 14	Actual	71	11.3	103	11.9	62	17.2	69	9.3	547	10.2
	Expected	64	10.2	74	8.6	31	8.7	58	7.8	456	8.5
15 - 19	Actual	70	11.1	109	12.6	49	13.6	105	14.2	660	12.3
	Expected	69	11.0	88	10.2	35	9.6	66	8.9	542	10.1
0 - 19	Actual	222	35.3	290	33.5	177	49.2	247	33.3	1697	31.6
	Expected	254	40.4	292	33.8	125	34.6	225	30.4	1799	33.5
20+	Actual	407	64.7	575	66.5	183	50.8	494	66.7	3672	68.4
	Expected	375	59.6	573	66.2	235	65.4	516	69.6	3570	66.5
TOTAL	Actual	629	100.0	865	100.0	360	100.0	741	100.0	5369	100.0
	Expected	629	100.0	865	100.0	360	100.0	741	100.0	5369	100.0

TABLE 10 (cont.)

[1] This table does not include certain specialized outpatient facilities.

[2] 'Expected' Number of Registrations is rounded to the nearest integer. It is the number of registrants one would expect for a given age group based on their share of the county population, eg. Total number of registrants x % of county population (0-4 years) = Expected Number of Registrations for the 0-4 age group.

[3] Expected % refers to the percentage of the County population (county in which the facility is located) which falls within a given age group. Figures in the table are derived from 1981 census data, provided by Statistics Canada.

[4] In the Row Total, "Expected %" is based on 1981 census data for the province as a whole.

TABLE 11 . Comparison of Staff Involved in initial Assessment of Outpatients,

by Age Group and Sex, for Thirteen Mental Health Facilities, 1981.

	(01)														
STAFF	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(5.3) 3	(4.3) 1	(5.0) 4	(6.2) 10	(8.6) 6	(6.9) 16	(11.4) 19	(8.2) 16	(9.7) 35	(2.2) 1	(4.8) 4	(3.9) 5	(7.7) 33	(7.3) 27	(7.5) 60
Other	(21.1) 12	(26.1) 6	(22.5) 18	(25.9) 42	(22.9) 16	(25.0) 58	(26.9) 45	(26.2) 51	(26.5) 96	(22.2) 10	(35.7) 30	(31.0) 40	(25.3) 109	(27.7) 103	(26.4) 212
Psychiatrist	(52.6) 30	(52.2) 12	(52.6) 42	(43.2) 70	(51.4) 36	(45.7) 106	(49.7) 83	(47.2) 92	(48.3) 175	(57.8) 26	(51.2) 43	(53.5) 69	(48.5) 209	(49.2) 183	(48.8) 392
Psychologist	-	-	-	(1.9) 3	-	(1.3) 3	-	(3.1) 6	(1.7) 6	-	-	-	(0.7) 3	(1.6) 6	(1.1) 9
Social Worker	(7.0) 4	(4.3) 1	(6.3) 5	(8.6) 14	(7.1) 5	(8.2) 19	(4.8) 8	(6.2) 12	(5.5) 20	(8.9) 4	(7.1) 6	(7.8) 10	(7.0) 30	(6.5) 24	(6.7) 54
Student	(14.0) 8	(13.0) 3	(13.8) 11	(14.2) 23	(10.0) 7	(12.9) 30	(7.2) 12	(9.2) 18	(8.3) 30	(8.9) 4	(1.2) 1	(3.9) 5	(10.9) 47	(7.8) 29	(9.5) 76
Total	(100.0) 57	(99.9) 23	(100.1) 80	(100.0) 162	(100.0) 70	(100.0) 232	(100.0) 167	(100.1) 195	(100.0) 362	(100.0) 45	(100.0) 84	(100.1) 129	(100.1) 431	(100.1) 372	(100.0) 803

TABLE 11 (cont.)

(02)

STAFF	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	(4.0) 1	-	(2.8) 1	-	(17.1) 6	(8.1) 6	(8.3) 3	(24.3) 9	(16.4) 12	(3.9) 4	(17.0) 15	(9.9) 19
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychiatrist	(66.7) 2	(60.0) 3	(62.5) 5	(8.0) 2	(9.1) 1	(8.3) 3	(41.0) 16	(22.9) 8	(32.4) 24	(47.2) 17	(45.9) 17	(46.6) 34	(35.9) 37	(33.0) 29	(34.6) 66
Psychologist	(33.3) 1	(20.0) 1	(25.0) 2	(88.0) 22	(90.9) 10	(88.9) 32	(38.5) 15	(22.9) 8	(31.1) 23	(8.3) 3	(21.6) 8	(15.1) 11	(39.8) 41	(30.7) 27	(35.6) 68
Social Worker	-	(20.0) 1	(12.5) 1	-	-	-	(20.5) 8	(22.9) 8	(21.6) 16	(36.1) 13	(8.1) 3	(21.9) 16	(20.4) 21	(13.6) 12	(17.3) 33
Student	-	-	-	-	-	-	-	(14.3) 5	(6.8) 5	-	-	-	-	(5.7) 5	(2.6) 5
Total	(100.0) 3	(100.0) 5	(100.0) 8	(100.0) 25	(100.0) 11	(100.0) 36	(100.0) 39	(100.1) 35	(100.0) 74	(99.9) 36	(99.9) 37	(100.0) 73	(100.0) 103	(100.0) 88	(100.0) 191

TABLE 11 (cont.)

STAFF	(03)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	-	-	-	(18.3) 21	(16.8) 16	(17.6) 37	(18.3) 21	(16.7) 16	(17.5) 37
Other	-	-	-	-	-	-	-	-	-	-	(1.1) 1	(0.5) 1	-	(1.0) 1	(0.5) 1
Psychiatrist	-	-	-	-	-	-	-	(100.0) 1	(100.0) 1	(33.0) 38	(33.7) 32	(33.3) 70	(33.0) 38	(34.4) 33	(33.6) 71
Psychologist	-	-	-	-	-	-	-	-	-	(3.5) 4	(1.1) 1	(2.4) 5	(3.5) 4	(1.0) 1	(2.4) 5
Social Worker	-	-	-	-	-	-	-	-	-	(17.4) 20	(18.9) 18	(18.1) 38	(17.4) 20	(18.8) 18	(18.0) 38
Student	-	-	-	-	-	-	-	-		(27.8) 32	(28.4) 27	(28.1) 59	(27.8) 32	(28.1) 27	(28.0) 59
Total	-	-	-	-	-	-	-	(100.0) 1	(100.0) 1	(100.0) 115	(100.0) 95	(100.0) 210	(100.0) 115	(100.0) 96	(100.0) 211

TABLE 11 (cont.)

(04)

STAFF	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	(17.2) 10	(8.8) 3	(14.1) 13	(12.2) 14	(15.0) 15	(13.5) 29	(13.0) 24	(13.0) 18	(13.0) 42
Other	-	-	-	-	-	-	(10.3) 6	(2.9) 1	(7.6) 7	(11.3) 13	(14.0) 14	(12.6) 27	(10.3) 19	(10.9) 15	(10.6) 34
Psychiatrist	(100.0) 1	-	(100.0) 1	(70.0) 7	(100.0) 4	(78.6) 11	(43.1) 25	(47.1) 16	(44.6) 41	(48.7) 56	(41.0) 41	(45.1) 97	(48.4) 89	(44.2) 61	(46.6) 150
Psychologist	-	-	-	-	-	-	(1.7) 1	(2.9) 1	(2.2) 2	(1.7) 2	(4.0) 4	(2.8) 6	(1.6) 3	(3.6) 5	(2.5) 8
Social Worker	-	-	-	(30.0) 3	-	(31.4) 3	(27.6) 16	(38.2) 13	(31.5) 29	(24.3) 28	(26.0) 26	(25.1) 54	(25.5) 47	(28.3) 39	(26.7) 86
Student	-	-	-	-	-	-	-	-	-	(1.7) 2	-	(0.9) 2	(1.1) 2	-	(0.6) 2
Total	(100.0) 1	-	(100.0) 1	(100.0) 10	(100.0) 4	(100.0) 14	(99.9) 58	(99.9) 34	(100.0) 92	(99.9) 115	(100.0) 100	(100.0) 215	(99.9) 184	(100.0) 138	(100.0) 322

TABLE 11 (cont.)

STAFF	(05)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	(2.5) 1	(6.3) 1	(3.6) 2	(5.1) 3	(14.0) 6	(8.8) 9	(2.5) 4	(8.6) 7	(4.6) 11
Other	(16.7) 1	-	(9.1) 1	(7.7) 4	-	(5.8) 4	(5.0) 2	-	(3.6) 2	-	(2.3) 1	(1.0) 1	(4.5) 7	(1.2) 1	(3.4) 8
Psychiatrist	-	-	-	-	(5.9) 1	(1.4) 1	(17.5) 7	(12.5) 2	(16.1) 9	(35.6) 21	(18.6) 8	(28.4) 29	(17.8) 28	(13.6) 11	(16.4) 39
Psychologist	(83.3) 5	(100.0) 5	(90.9) 10	(88.5) 46	(94.1) 16	(89.9) 62	(60.0) 24	(81.3) 13	(66.1) 37	(45.8) 27	(27.9) 12	(38.2) 39	(65.0) 102	(56.8) 46	(62.2) 148
Social Worker	-	-	-	(3.8) 2	-	(2.9) 2	(12.5) 5	-	(8.9) 5	(13.6) 8	(37.2) 16	(23.5) 24	(9.6) 15	(19.8) 16	(13.0) 31
Student	-	-	-	-	-	-	(2.5) 1	-	(1.8) 1	-	-	-	(0.6) 1	-	(0.4) 1
Total	(100.0) 6	(100.0) 5	(100.0) 11	(100.0) 52	(100.0) 17	(100.0) 69	(100.0) 40	(100.1) 16	(100.1) 56	(100.1) 59	(100.0) 43	(99.9) 102	(100.0) 157	(100.0) 81	(100.0) 238

TABLE 11 (cont.)

	(06)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
STAFF	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(61.5) 8	(66.7) 2	(62.5) 10	(54.5) 12	(60.0) 9	(56.8) 21	(12.5) 4	(18.8) 3	(14.6) 7	-	(29.7) 11	(15.9) 11	(24.2) 24	(35.2) 25	(28.8) 29
Other	-	-	-	-	-	-	(3.1) 1		(2.1) 1	-	-	-	(1.0) 1	-	(0.6) 1
Psychiatrist	(30.8) 4	-	(25.0) 4	(40.9) 9	(13.3) 2	(29.7) 11	(18.8) 6	(18.8) 3	(18.8) 9	(28.1) 9	18.9) 7	(23.2) 16	(28.3) 28	(16.9) 12	(23.5) 40
Psychologist	-	-	-	-	(13.3) 2	(5.4) 2	(6.3) 2	-	(4.2) 2	(12.5) 4	(8.1) 3	(10.0) 7	(6.1) 6	(7.0) 5	(6.5) 11
Social Worker	(7.7) 1	(33.3) 1	(12.5) 2	(4.5) 1	(13.3) 2	(8.1) 3	(59.4) 19	(62.5) 10	(60.4) 29	(59.4) 19	(43.2) 16	(50.7) 35	(40.4) 40	(40.8) 29	(40.6) 69
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.00) 13	(100.0) 3	(100.0) 16	(99.9) 22	(99.9) 15	(100.0) 37	(100.1) 32	(100.1) 16	(100.1) 48	(100.0) 32	(99.9) 37	(99.9) 69	(100.0) 99	(99.9) 71	(100.0) 170

TABLE 11 (cont.)

STAFF	(07)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	-	-	-	-	(3.8) 1	(2.6) 1	-	(2.0) 1	(0.9) 1
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychiatrist	-	-	-	(15.8) 3	-	(12.0) 3	(37.9) 11	(33.3) 6	(36.2) 17	(61.5) 8	(46.2) 12	(51.3) 20	(34.9) 22	(35.3) 18	(35.1) 40
Psychologist	(100.0) 2	(100.0) 1	(100.0) 3	(84.2) 16	(100.0) 6	(88.0) 22	(44.8) 13	(44.4) 8	(44.7) 21	(23.1) 3	(19.2) 5	(20.5) 8	(54.0) 34	(39.2) 20	(47.4) 54
Social Worker	-	-	-	-	-	-	(17.2) 5	(22.2) 4	(19.1) 9	(15.4) 2	(30.8) 8	(25.6) 10	(11.1) 7	(23.5) 12	(16.7) 19
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.0) 2	(100.0) 1	(100.0) 3	(100.0) 19	(100.0) 6	(100.0) 25	(99.9) 29	(99.9) 18	(100.0) 47	(100.0) 13	(100.0) 26	(100.0) 39	(100.0) 63	(100.0) 51	(100.1) 114

TABLE 11 (cont.)

(OB)

STAFF	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	(2.7) 1	(14.3) 2	(5.9) 3	(3.1) 1	(15.2) 5	(9.2) 6	(2.5) 2	(13.5) 7	(6.9) 9
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychiatrist	(33.3) 1	(50.0) 1	(40.0) 2	-	-	-	(16.2) 6	(21.4) 3	(17.6) 9	(40.6) 13	(36.4) 12	(38.5) 25	(25.3) 20	(30.8) 16	(27.5) 36
Psychologist	(66.7) 2	(50.0) 1	(60.0) 3	(71.4) 5	(66.7) 2	(70.0) 7	(45.9) 17	(50.0) 7	(47.1) 24	(34.4) 11	(18.2) 6	(26.2) 17	(44.3) 35	(30.8) 16	(38.9) 51
Social Worker	-	-	-	(28.6) 2	(33.3) 1	(30.0) 3	(35.1) 13	(14.3) 2	(29.4) 15	(21.9) 7	(30.3) 10	(26.2) 17	(27.8) 22	(25.0) 13	(26.7) 35
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.0) 3	(100.0) 2	(100.0) 5	(100.0) 7	(100.0) 3	(100.0) 10	(99.9) 37	(100.0) 14	(100.0) 51	(100.0) 32	(100.1) 33	(100.1) 65	(99.9) 79	(100.1) 52	(100.0) 131

TABLE 11 (cont.)

(09)

STAFF	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	-	-	-	-	(2.6) 1	(1.4) 1	-	(1.1) 1	(0.5) 1
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychiatrist	-	-	-	(2.2) 1	(6.7) 1	(3.3) 2	(10.6) 5	(20.8) 5	(14.1) 10	(59.4) 19	(47.4) 18	(52.9) 37	(18.9) 25	(27.0) 24	(22.2) 49
Psychologist	(100.0) 7	(100.0) 12	(100.0) 19	(95.7) 44	(86.7) 13	(93.4) 57	(87.2) 41	(66.7) 16	(80.3) 57	(28.1) 9	(23.7) 9	(25.7) 18	(76.5) 101	(56.2) 50	(68.3) 151
Social Worker	-	-	-	(2.2) 1	(6.7) 1	(3.3) 2	(2.1) 1	(12.5) 3	(5.6) 4	(12.5) 4	(26.3) 10	(20.0) 14	(4.5) 6	(15.7) 14	(9.0) 20
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.0) 7	(100.0) 12	(100.0) 19	(100.1) 46	(100.1) 15	(100.0) 61	(99.9) 47	(100.0) 24	(100.0) 71	(100.0) 32	(100.0) 38	(100.0) 70	(99.9) 132	(100.0) 89	(100.0) 221

TABLE 11 (cont.)

STAFF	(10)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	(1.7) 1	(2.3) 1	(1.9) 2	(3.0) 3	(22.4) 11	(9.3) 14	(1.7) 1	(17.1) 13	(10.4) 14	(2.2) 5	(14.5) 25	(7.5) 30
Other	-	-	-	(1.7) 1	-	(1.0) 1	-	-	-	(6.9) 4	(1.3) 1	(3.7) 5	(2.2) 5	(0.6) 1	(1.5) 6
Psychiatrist	-	-	-	(5.1) 3	(2.3) 1	(3.9) 4	(3.0) 3	(4.1) 2	(3.3) 5	(20.7) 12	(21.1) 16	(20.9) 28	(8.0) 18	(11.0) 19	(9.3) 37
Psychologist	(87.5) 7	(50.0) 2	(75.0) 9	(61.0) 36	(63.6) 28	(62.1) 64	(52.5) 53	(42.9) 21	(49.3) 74	(48.3) 28	(32.9) 25	(39.6) 53	(54.9) 124	(43.9) 76	(50.1) 200
Social Worker	-	(25.0) 1	(8.3) 1	(16.9) 10	(22.7) 10	(19.4) 20	(26.7) 27	(14.3) 7	(22.7) 34	(17.2) 10	(21.1) 16	(19.4) 26	(20.8) 47	(19.7) 34	(20.3) 81
Student	(12.5) 1	(25.0) 1	(16.7) 2	(13.6) 8	(9.1) 4	(11.7) 12	(14.9) 15	(16.3) 8	(15.3) 23	(5.2) 3	(6.6) 5	(6.0) 8	(11.9) 27	(10.4) 18	(11.3) 45
Total	(100.0) 8	(100.0) 4	(100.0) 12	(100.0) 59	(100.0) 44	(100.0) 103	(100.1) 101	(100.0) 49	(99.9) 150	(100.0) 58	(100.1) 76	(100.0) 134	(100.0) 226	(100.1) 173	(100.0) 399

TABLE 11 (cont.)

STAFF	(11) 0 - 4 years Male	 0 - 4 years Female	 0 - 4 years Both	 5 - 9 years Male	 5 - 9 years Female	 5 - 9 years Both	 10 - 14 years Male	 10 - 14 years Female	 10 - 14 years Both	 15 - 19 years Male	 15 - 19 years Female	 15 - 19 years Both	 0 - 19 years Male	 0 - 19 years Female	 0 - 19 years Both
Nurses	(11.1) 1	-	(7.7) 1	-	-	-	(2.1) 1	(14.3) 2	(4.9) 3	(3.6) 1	(13.6) 3	(8.0) 4	(2.4) 3	(9.6) 5	(4.5) 8
Other	-	-		-	-	-	-	-	-	-	-	-	-	-	-
Psychiatrist	-	-	-	-	-	-	-	-	-	(14.3) 4	(4.5) 1	(10.0) 5	(3.2) 4	(1.9) 1	(2.8) 5
Psychologist	(88.9) 8	(100.0) 4	(92.3) 12	(97.6) 40	(100.0) 12	(98.1) 52	(85.1) 40	(78.6) 11	(83.6) 51	(50.0) 14	(31.8) 7	(42.0) 21	(81.6) 102	(65.4) 34	(76.8) 136
Social Worker	-	-	-	-	-	-	(10.6) 5	-	(8.2) 5	(25.0) 7	(45.5) 10	(34.0) 17	(9.6) 12	(19.2) 10	(12.4) 22
Student	-	-	-	(2.4) 1	-	(1.9) 1	(2.1) 1	(7.1) 1	(3.3) 2	(7.1) 2	(4.5) 1	(6.0) 3	(3.2) 4	(3.8) 2	(3.4) 6
Total	(100.0) 9	(100.0) 4	(100.0) 13	(100.0) 41	(100.0) 12	(100.0) 53	(99.9) 47	(100.0) 14	(100.0) 61	(100.0) 28	(99.9) 22	(100.0) 50	(100.0) 125	(99.9) 52	(99.9) 177

TABLE 11 (cont.)

STAFF	(12)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(8.3) 1	-	(5.0) 1	(14.0) 7	(13.6) 3	(13.9) 10	(19.0) 11	(34.4) 11	(24.4) 22	(12.5) 5	(36.8) 32	(29.1) 37	(15.0) 24	(30.9) 45	(22.7) 70
Other	-	-	-	-	-	-	-	-	-	(7.5) 3	-	(2.4) 3	(1.9) 3	-	(1.0) 3
Psychiatrist	(8.3) 1	-	(5.0) 1	(6.0) 3	(4.5) 1	(5.6) 4	(6.9) 4	(6.3) 2	(6.7) 6	(17.5) 7	(6.9) 6	(10.2) 13	(9.4) 15	(6.0) 9	(7.8) 24
Psychologist	(66.7) 8	(12.5) 7	(75.0) 15	(58.0) 29	(63.6) 14	(59.7) 43	(44.8) 26	(28.1) 9	(38.9) 35	(32.5) 13	(17.2) 15	(22.0) 28	(47.5) 76	(30.2) 45	(39.2) 121
Social Worker	(16.7) 2	(87.5) 1	(15.0) 3	(22.0) 11	(18.2) 4	(20.8) 15	(29.3) 17	(31.3) 10	(30.0) 27	(30.0) 12	(39.1) 34	(36.2) 46	(26.3) 42	(32.9) 49	(29.4) 91
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.0) 12	(100.0) 8	(100.0) 20	(100.0) 50	(99.9) 22	(100.0) 72	(100.0) 58	(100.1) 32	(100.0) 90	(100.0) 40	(100.0) 87	(99.9) 127	(100.1) 160	(100.0) 149	(100.1) 309

TABLE 11 (cont.)

	(13)														
STAFF	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(4.3) 4	(1.7) 1	(3.3) 5	(5.6) 13	(6.6) 9	(6.0) 22	(2.1) 5	(2.9) 5	(2.4) 10	(1.0) 1	(1.4) 1	(12.) 2	(3.5) 23	(3.6) 16	(3.5) 39
Other	(15.2) 14	(3.4) 2	(10.6) 16	(14.2) 33	(23.5) 32	(17.7) 65	(6.7) 16	(6.9) 12	(6.8) 28	(1.0) 1	(2.8) 2	(1.7) 3	(9.6) 64	(10.9) 48	(10.1) 112
Psychiatrist	(5.4) 5	(1.7) 1	(4.0) 6	(4.7) 11	(4.4) 6	(4.6) 17	(8.3) 20	(11.0) 19	(9.4) 39	(13.9) 14	(9.9) 7	(12.2) 21	(7.5) 50	(7.5) 33	(7.5) 83
Psychologist	(37.0) 34	(50.8) 30	(42.4) 64	(40.9) 95	(31.6) 93	(37.5) 138	(49.6) 119	(36.4) 63	(44.1) 182	(58.4) 59	(38.0) 27	(50.0) 86	(46.2) 307	(37.1) 163	(42.6) 470
Social Worker	(34.8) 32	(37.3) 22	(35.8) 54	(29.3) 68	(27.2) 37	(28.5) 105	(26.7) 64	(35.8) 62	(30.5) 126	(21.8) 22	(42.3) 30	(30.2) 52	(28.0) 186	(34.4) 151	(30.5) 337
Student	(3.3) 3	(5.1) 3	(4.0) 6	(5.2) 12	(6.6) 9	(5.7) 21	(6.7) 13	(6.9) 12	(6.8) 28	(4.0) 4	(5.6) 4	(4.7) 8	(5.3) 35	(6.4) 28	(5.7) 63
Total	(100.0) 92	(100.0) 59	(100.1) 151	(99.9) 232	(99.9) 136	(100.0) 368	(100.1) 240	(99.9) 173	(100.0) 413	(100.1) 101	(100.0) 71	(100.0) 172	(100.1) 665	(99.9) 439	(99.9) 1104

TABLE 11 (cont.)

ROW TOTALS

STAFF	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(8.0) 17	(3.2) 4	(6.2) 21	(6.1) 44	(7.9) 28	(6.7) 72	(6.1) 55	(9.7) 60	(7.6) 115	(7.2) 51	(15.6) 117	(11.5) 168	(6.6) 167	(11.3) 209	(8.6) 376
Other	(12.7) 27	(6.3) 8	(10.3) 35	(11.0) 80	(13.5) 48	(11.9) 128	(7.8) 70	(10.3) 64	(8.8) 134	(4.4) 31	(6.5) 49	(5.5) 80	(8.2) 208	(9.1) 169	(8.6) 377
Psychiatrist	(20.7) 44	(13.5) 17	(18.0) 61	(15.0) 109	(14.9) 53	(15.0) 162	(20.8) 186	(25.6) 159	(22.8) 345	(34.6) 244	(29.4) 220	(31.9) 464	(23.0) 583	(24.3) 449	(23.5) 1032
Psychologist	(34.7) 74	(50.0) 63	(40.4) 137	(46.3) 336	(41.1) 146	(44.6) 482	(39.2) 351	(26.2) 163	(33.9) 514	(25.1) 177	(16.3) 122	(20.5) 299	(36.9) 938	(26.7) 494	(32.6) 1432
Social Worker	(18.3) 39	(21.4) 27	(19.5) 66	(15.4) 112	(16.9) 60	(15.9) 172	(21.0) 188	(21.1) 131	(21.0) 319	(22.1) 156	(27.1) 203	(24.7) 359	(19.5) 495	(22.7) 421	(20.9) 916
Student	(5.6) 12	(5.6) 7	(5.6) 19	(6.1) 44	(5.6) 20	(5.9) 64	(5.0) 45	(7.1) 44	(5.9) 89	(6.7) 47	(5.1) 38	(5.8) 85	(5.8) 148	(5.9) 109	(5.9) 257
Total	(100.0) 213	(100.0) 126	(100.0) 339	(99.9) 725	(99.9) 355	(100.0) 1080	(99.9) 895	(100.0) 621	(100.0) 1516	(100.1) 706	(100.0) 749	(99.9) 1455	(100.0) 2539	(100.0) 1851	(100.1) 4390

1981. Once again, there is evidence of a high degree of variability from one facility to another. To a considerable extent, whether a young person is assessed by a psychiatrist, psychologist or social worker, in Nova Scotia, depends on which facility he or she happens to visit. Whether the young person is in fact a "he" or a "she" also appears to affect the profession likely to do the assessment, with psychologists assessing 36.9 percent of the males but only 26.7 percent of females. It is unclear why this should be so. For both sexes taken together, across all facilities, psychologists accounted for 32.6 percent of initial assessments, psychiatrists for 23.5 percent, and social workers for 20.9 percent. However, the table fails to show that in some cases more than one staff member actually saw the patient/client, while in a large number of cases the staff member who interviewed consulted with colleagues in other professions.

After the initial assessment, which profession provides the actual treatment? Table 12, however, deals not with "treatment" per se but with "contacts". It will be recalled that a "contact" means a communication either with the patient/client (whether in person or by telephone) or on behalf of the patient/client. The proportion of contacts involving a psychiatrist varied considerably from facility to facility, the range being from less than 1 percent (facility 11) to 48 percent (facility 01). The average proportion of contacts made by psychiatrists was 12.5 percent for all facilities taken together. For those who associate a mental health facility with treatment provided by a psychiatrist, it is interesting to note that, overall, psychologists were involved with 41.7 percent of contacts and social workers with 26.1 percent. Thus, only about one eighth of actual contacts in mental health centres dealing with young people involve psychiatrists, more than twice that many involve social workers, and better than three times as many involve psychologists.

The psychiatrists are also more likely to see older than younger outpatients. Some 18.1 percent of contacts with or for 15-19 year olds

TABLE 12

COMPARISON OF STAFF INVOLVED IN OUTPATIENT CONTACT, BY AGE GROUP AND SEX, FOR THIRTEEN MENTAL HEALTH FACILITIES, 1981.

	(01)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
STAFF	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(12.2) 6	(30.4) 17	(21.9) 23	(5.1) 12	(15.2) 12	(7.6) 24	(13.1) 32	(10.1) 29	(11.5) 61	(16.7) 20	(8.8) 35	(10.6) 55	(10.8) 70	(11.3) 93	(11.1) 163
Other	(8.2) 4	(26.8) 15	(18.1) 19	(9.4) 22	(15.2) 12	(10.8) 34	(14.3) 35	(12.2) 35	(13.2) 70	(16.7) 20	(19.0) 76	(18.5) 96	(12.5) 81	(16.8) 138	(14.9) 219
Psychiatrist	(42.9) 21	(30.4) 17	(36.2) 38	(54.0) 127	(38.0) 30	(50.0) 157	(57.1) 140	(48.6) 139	(52.5) 279	(65.0) 78	(37.8) 151	(44.0) 229	(56.4) 366	(41.0) 337	(47.8) 703
Psychologist	-	(1.8) 1	(1.0) 1	(0.4) 1	-	(0.3) 1	(0.8) 2	(0.3) 1	(0.6) 3	-	(0.8) 3	(0.6) 3	(0.5) 3	(0.5) 5	(0.5) 8
Social Worker	(14.3) 7	(3.6) 2	(8.6) 9	(19.1) 45	(19.0) 15	(19.1) 60	(6.5) 16	(22.7) 65	(15.3) 81	-	(32.0) 128	(24.6) 3	(10.5) 68	(25.6) 210	(18.9) 278
Student	(22.4) 11	(7.1) 4	(14.3) 15	(11.9) 28	(12.7) 10	(12.7) 38	(8.2) 20	(5.9) 17	(7.0) 37	(1.7) 2	(1.8) 7	(1.7) 9	(9.4) 61	(4.6) 38	(6.7) 99
Total	(100.0) 49	(100.1) 56	(100.1) 105	(99.9) 235	(100.1) 79	(99.9) 314	(100.0) 245	(99.8) 286	(100.1) 531	(100.1) 120	(100.2) 400	(100.0) 520	(100.1) 649	(99.8) 821	(99.9) 1470

TABLE 12 (cont.)

	(02)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
STAFF	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(16.7) 1	(12.5) 8	(12.9) 9	-	-	-	-	(10.9) 41	(5.2) 41	(7.3) 20	(20.6) 74	(13.7) 102	(2.8) 29	(14.6) 123	(8.0) 152
Other	-	-	-	-	-	-	-	-	-	(0.8) 3	(3.9) 14	(2.3) 17	(0.3) 3	(1.7) 14	(0.9) 17
Psychiatrist	(16.7) 1	(20.3) 13	(20.0) 14	(4.0) 10	-	(3.4) 10	(7.6) 31	(11.4) 43	(9.4) 74	(25.3) 97	(31.5) 113	(28.3) 210	(13.2) 139	(20.0) 169	(16.3) 308
Psychologist	(16.7) 1	(35.9) 23	(34.3) 24	(95.7) 242	(97.7) 42	(95.9) 284	(81.9) 334	(72.9) 275	(77.6) 609	(28.7) 110	(21.4) 77	(25.2) 187	(65.4) 687	(49.5) 417	(58.3) 1104
Social Worker	(50.0) 3	(29.7) 19	(31.4) 22	(0.4) 1	(2.3) 1	(0.7) 2	(10.5) 43	(4.8) 18	(7.8) 61	(37.9) 145	(22.6) 81	(30.5) 226	(18.3) 192	(14.1) 119	(16.4) 311
Student	-	(1.6) 1	(1.4) 1	-	-	-	-	-	-	-	-	-	-	(0.1) 1	(0.1) 1
Total	(100.1) 6	(100.0) 64	(100.0) 70	(100.1) 253	(100.0) 43	(100.0) 296	(100.0) 408	(100.0) 377	(100.0) 785	(100.0) 383	(100.0) 359	(100.0) 742	(100.0) 1050	(100.0) 843	(100.0) 1893

TABLE 12 (cont.)

STAFF	(03)														
	0 - 4 years.			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-		(53.6) 15	(53.6) 15	(19.0) 45	(25.9) 103	(23.3) 148	(19.0) 45	(27.8) 118	(24.6) 163
Other	-	-	-	-	-	-		-	-	(10.1) 24	(9.3) 37	(9.6) 61	(10.1) 24	(8.7) 37	(9.2) 61
Psychiatrist	-	-	-	-	-	-		(21.4) 6	(21.4) 6	(32.5) 77	(21.9) 87	(25.9) 164	(32.5) 77	(21.9) 93	(25.7) 170
Psychologist	-	-	-	-	-	-		-	-	(2.5) 6	(1.5) 6	(1.9) 12	(2.5) 6	(1.4) 6	(1.8) 12
Social Worker	-	-	-	-	-	-		-	-	(19.8) 47	(29.7) 118	(26.0) 165	(19.8) 47	(27.8) 118	(24.9) 165
Student	-	-	-	-	-	-		(25.0) 7	(25.0) 7	(16.0) 38	(11.6) 46	(13.2) 84	(16.0) 38	(12.5) 53	(13.7) 91
Total	-	-	-	-	-	-		(100.0) 28	(100.0) 28	(99.9) 237	(99.9) 397	(99.9) 634	(99.9) 237	(100.1) 425	(99.9) 662

TABLE 12 (cont.)

	(04)														
STAFF	0 - 4 years.			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	-	-	-	(13.1) 40	(12.1) 22	(12.7) 62	(11.9) 40	(11.3) 22	(11.7) 62
Other	-	-	-	-	-	-	(18.5) 5	-	(12.8) 5	(9.5) 29	(13.2) 24	(10.9) 53	(10.1) 34	(12.4) 24	(11.0) 58
Psychiatrist	(100.0) 1	-	(100.0) 1	(100.0) 1	-	(100.0) 1	(29.6) 8	(58.3) 7	(38.5) 15	(48.4) 148	(30.8) 56	(41.8) 204	(47.2) 158	(32.5) 63	(41.8) 221
Psychologist	-	-	-	-	-	-	-	-	-	(5.2) 16	(8.8) 16	(6.6) 32	(4.8) 16	(8.2) 16	(6.0) 32
Social Worker	-	-	-	-	-	-	(51.9) 14	(33.3) 4	(46.2) 18	(21.6) 66	(33.5) 61	(26.0) 127	(23.9) 80	(33.9) 65	(27.4) 145
Student	-	-	-	-	-	-	-	(8.3) 1	(2.6) 1	(2.3) 7	(1.6) 3	(2.0) 10	(2.1) 7	(2.1) 4	(2.1) 11
Total	(100.0) 1	-	(100.0) 1	(100.0) 1	-	(100.0) 1	(100.0) 27	(99.9) 12	(100.1) 39	(100.1) 306	(100.0) 182	(100.0) 488	(100.0) 335	(100.0) 194	(100.0) 529

TABLE 12 (cont.)

STAFF	(05)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
				(2.7)		(1.8)	(2.3)	(10.3)	(3.5)	(11.7)	(14.7)	(13.4)	(6.4)	(12.4)	(8.9)
Nurses	-	-	-	3	-	3	5	4	9	30	49	79	38	53	91
				(1.8)		(1.2)	(1.4)	(2.6)	(1.5)	(2.7)	(4.2)	(3.6)	(2.0)	(3.5)	(2.7)
Other	-	-	-	2	-	2	3	1	4	7	14	21	12	15	27
				(2.7)	(3.7)	(3.0)	(8.6)		(7.3)	(17.1)	(8.1)	(12.0)	(11.2)	(6.8)	(9.3)
Psychiatrist	-	-	-	3	2	5	19	-	19	44	27	71	66	29	95
	(100.0)	(100.0)	(100.0)	(88.3)	(94.4)	(90.3)	(52.9)	(79.5)	(56.9)	(45.9)	(12.3)	(26.9)	(56.6)	(29.0)	(45.0)
Psychologist	1	1	2	98	51	149	117	31	140	118	41	159	334	124	458
				(4.5)	(1.9)	(3.6)	(34.8)	(7.7)	(30.8)	(22.6)	(59.8)	(43.6)	(23.7)	(47.5)	(33.7)
Social Worker	-	-	-	5	1	6	77	3	80	58	199	257	140	203	343
											(0.9)	(0.5)		(0.7)	(0.3)
Student	-	-	-	-	-	-	-	-	-	-	3	3	-	3	3
	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(99.9)	(100.0)	(100.1)	(100.0)	(100.0)	(100.0)	(100.0)	(99.9)	(99.9)	(99.9)
Total	1	1	2	111	54	165	221	39	260	257	333	590	590	427	1017

TABLE 12 (cont.)

STAFF	(06)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(79.2) 19	(83.3) 5	(80.0) 24	(84.0) 163	(89.8) 53	(85.4) 216	(55.2) 127	(52.0) 39	(54.4) 166	(2.8) 5	(52.4) 143	(32.8) 148	(50.2) 314	(58.1) 240	(53.3) 554
Other	-	-	-	(2.6) 5	-	(2.0) 5	-	(1.3) 1	(0.3) 1	-	-	-	(0.8) 5	(0.2) 1	(0.6) 6
Psychiatrist	(12.5) 3	-	(10.0) 3	(7.7) 15	(5.1) 3	(7.1) 18	(5.2) 12	(2.7) 2	(4.6) 14	(7.3) 13	(5.5) 15	(6.2) 28	(6.9) 43	(4.8) 20	(6.1) 63
Psychologist	-	-	-	(3.1) 6	-	(2.4) 6	(11.7) 27	(1.3) 1	(9.2) 28	(29.2) 52	(4.8) 13	(14.4) 5	(13.6) 85	(3.4) 14	(9.5) 99
Social Worker	(8.3) 2	(16.7) 1	(10.0) 3	(2.6) 5	(5.1) 3	(3.2) 8	(27.8) 64	(42.7) 32	(31.5) 96	(60.7) 108	(37.4) 102	(46.6) 210	(28.6) 179	(33.4) 138	(30.5) 317
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.0) 24	(100.0) 6	(100.0) 30	(100.0) 194	(100.0) 59	(100.1) 253	(99.9) 230	(100.0) 75	(100.0) 305	(100.0) 178	(100.1) 273	(100.0) 451	(100.1) 626	(99.9) 413	(100.0) 1039

TABLE 12 (cont.)

	(07)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
STAFF	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	(0.3) 1	-	(0.2) 1	(5.9) 27	(9.2) 18	(6.9) 45	(7.7) 6	(25.1) 82	(21.7) 88	(3.6) 34	(18.0) 100	(9.0) 134
Other	-	-	-	-	-	-	(0.4) 2	-	(0.3) 2	(2.6) 2	(2.8) 9	(2.7) 11	(0.4) 4	(1.6) 9	(0.9) 13
Psychiatrist	-	-	-	(2.0) 8	-	(1.9) 8	(8.9) 41	(3.1) 6	(7.2) 47	(38.5) 30	(17.4) 57	(21.5) 87	(8.4) 79	(11.4) 63	(9.5) 142.
Psychologist	(100.0) 7	(100.0) 2	(100.0) 9	(97.4) 381	(100.0) 31	(97.6) 412	(82.0) 381	(85.6) 167	(83.7) 548	(34.6) 27	(36.4) 119	(36.0) 146	(85.0) 796	(57.5) 319	(74.8) 1115
Social Worker	-	-	-	(0.3) 1	-	(0.2) 1	(2.0) 9	(2.1) 4	(2.0) 13	(16.7) 13	(18.3) 60	(18.0) 73	(2.5) 23	(11.5) 64	(5.8) 87
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.00) 7	(100.0) 2	(100.0) 9	(100.0) 391	(100.0) 31	(99.9) 422	(100.0) 460	(100.0) 195	(100.1) 655	(100.1) 78	(100.0) 327	(99.9) 405	(99.9) 936	(100.0) 555	(100.0) 1491

TABLE 12 (cont.)

	(00)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
STAFF	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	(13.4) 17	(8.1) 5	(11.6) 22	(13.4) 25	(12.5) 22	(13.0) 47	(12.2) 42	(10.6) 27	(11.5) 69
Other	-	-	-	-	-	-	(2.4) 3	-	(1.6) 3	(5.9) 11	-	(3.0) 11	(4.1) 14	-	(2.3) 14
Psychiatrist	-	-	-	-	-	-	(7.9) 10	(12.9) 8	(9.5) 18	(9.7) 18	(13.1) 23	(11.3) 41	(8.1) 28	(12.2) 31	(9.8) 59
Psychologist	(100.0) 7	(100.0) 2	(100.0) 9	(91.7) 22	(100.0) 15	(94.9) 37	(43.3) 55	(79.0) 49	(55.0) 104	(24.2) 45	(21.6) 38	(22.9) 83	(37.5) 129	(40.8) 104	(38.9) 233
Social Worker	-	-	-	(8.3) 2	-	(5.1) 2	(33.1) 42	-	(22.2) 42	(46.8) 87	(52.8) 93	(49.7) 180	(38.1) 131	(36.5) 93	(37.4) 224
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.0) 7	(100.0) 2	(100.0) 9	(100.0) 24	(100.0) 15	(100.0) 39	(100.1) 127	(100.0) 62	(100.0) 189	(100.0) 186	(100.0) 176	(99.9) 362	(100.0) 344	(100.1) 255	(99.9) 599

TABLE 12 (cont.)

STAFF	(09)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	-	-	-	-	(1.4) 2	(0.6) 2	-	-	-	-	(0.5) 2	(0.2) 2
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychiatrist	-	-	-	(0.9) 1	(6.5) 2	(2.1) 3	(3.2) 7	(5.8) 8	(4.2) 15	(38.1) 74	(15.6) 31	(26.7) 105	(16.2) 82	(10.8) 41	(15.2) 123
Psychologist	(92.9) 12	(100.0) 10	(95.8) 23	(89.6) 103	(90.3) 28	(89.7) 131	(72.5) 158	(52.9) 73	(64.9) 231	(30.4) 59	(22.6) 45	(26.5) 104	(61.6) 333	(41.3) 156	(53.2) 489
Social Worker	(7.1) 1	1	(4.2) 1	(9.6) 11	(3.2) 1	(8.2) 12	(24.3) 53	(39.9) 55	(30.3) 108	(31.4) 61	(61.8) 123	(46.8) 184	(23.3) 126	(47.4) 179	(33.2) 305
Student	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	(100.0) 13	(100.0) 11	(100.0) 24	(100.1) 115	(100.0) 31	(100.0) 146	(100.0) 218	(100.0) 138	(100.0) 356	(99.9) 194	(100.0) 199	(100.0) 393	(100.1) 541	(100.0) 378	(100.0) 919

TABLE 12 (cont.)

	(10)														
STAFF	0 - 4 years.			5 - 9 years			10 - 14 years			16 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	(7.5) 3	-	(4.5) 3	(6.2) 9	(15.0) 18	(10.2) 27	(1.8) 3	(30.8) 100	(24.1) 103	(4.2) 15	(28.7) 118	(17.3) 133
Other	(20.0) 1	-	(8.3) 1	-	-	-	(1.4) 2	(0.8) 1	(1.1) 3	(1.8) 3	(1.6) 4	(1.6) 7	(1.7) 6	(1.2) 5	(1.4) 11
Psychiatrist	-	-	-	(12.5) 5	-	(7.6) 5	(5.5) 8	(4.2) 5	(4.9) 13	(29.0) 49	(13.2) 34	(19.4) 83	(17.3) 62	(9.5) 39	(13.1) 101
Psychologist	(80.0) 4	(71.4) 5	(75.0) 9	(75.0) 30	(88.5) 23	(80.3) 53	(39.3) 57	(40.0) 48	(39.6) 105	(34.3) 58	(19.8) 51	(25.5) 109	(41.5) 149	(30.9) 127	(35.8) 276
Social Worker	-	(28.6) 2	(16.7) 2	(5.0) 2	(3.8) 1	(4.5) 3	(43.4) 63	(30.8) 37	(37.7) 100	(27.8) 47	(21.3) 55	(23.9) 102	(31.2) 112	(23.1) 95	(26.9) 207
Student	-	-	-	-	(7.7) 2	(3.0) 2	(4.1) 6	(9.2) 11	(6.4) 17	(5.3) 9	(5.4) 14	(5.4) 23	(4.2) 15	(6.6) 27	(5.5) 42
Total	(100.0) 5	(100.0) 7	(100.0) 12	(100.0) 40	(100.0) 26	(99.9) 66	(99.9) 145	(100.0) 120	(99.9) 265	(100.0) 169	(100.1) 258	99.9) 427	(100.1) 359	(100.0) 411	(100.0) 770

TABLE 12 (cont.)

STAFF	(11)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	-	-	-	(6.4) 14	-	(4.4) 14	(6.0) 27	(14.3) 9	(7.0) 36	(10.7) 16	(24.2) 44	(18.1) 60	(6.9) 57	(15.4) 53	(9.4) 110
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychiatrist	-	-	-	-	-	-	(0.4) 2	(1.6) 1	(0.6) 3	(2.7) 4	(0.5) 1	(1.5) 5	(0.7) 6	(0.6) 2	(0.7) 8
Psychologist	(100.0) 11	-	(100.0) 11	(89.0) 195	(94.0) 94	(90.6) 289	(83.8) 379	(77.8) 49	(83.1) 428	(67.8) 101	(23.1) 42	(43.2) 143	(82.6) 686	(53.6) 185	(74.1) 871
Social Worker	-	-	-	(2.7) 6	(6.0) 6	(3.8) 12	(9.1) 41	-	(8.0) 41	(12.8) 19	(51.6) 94	(34.1) 113	(7.9) 66	(29.0) 100	(14.1) 166
Student	-	-	-	(1.8) 4	-	(1.3) 4	(0.7) 3	(6.3) 4	(1.4) 7	(6.0) 9	(0.5) 1	(3.0) 10	(1.9) 16	(1.4) 5	(1.8) 21
Total	(100.0) 11	-	(100.0) 11	(99.9) 219	(100.0) 100	(100.1) 319	(100.0) 452	(100.0) 63	(100.1) 515	(100.0) 149	(99.9) 182	(99.9) 331	(100.0) 831	(100.0) 345	(100.1) 1176

TABLE 12 (cont.)

	(12)														
STAFF	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(3.7) 1	-	(2.1) 1	(2.4) 6	(17.2) 15	(6.2) 21	(11.9) 26	(37.0) 74	(23.9) 100	(12.1) 53	(35.7) 148	(23.6) 201	(9.2) 86	(32.8) 237	(19.5) 323
Other	-	-	-	(1.2) 3	(1.1) 1	(1.2) 4	(0.9) 2	(1.0) 2	(1.0) 4	(0.9) 4	(0.5) 2	(0.7) 6	(1.0) 9	(0.7) 5	(0.8) 14
Psychiatrist	(7.4) 2	-	(4.2) 2	(9.2) 23	(9.2) 8	(9.2) 31	(15.1) 33	(11.0) 22	(13.1) 55	(15.7) 69	(7.7) 32	(11.8) 101	(13.6) 127	(8.6) 62	(11.4) 189
Psychologist	(74.1) 20	(100.0) 21	(85.4) 41	(75.3) 189	(52.9) 46	(69.5) 235	(39.3) 86	(33.0) 66	(36.3) 152	(36.4) 160	(11.4) 47	(24.3) 207	(48.6) 455	(24.9) 180	(38.3) 635
Social Worker	(14.8) 4	-	(8.3) 4	(12.0) 30	(19.5) 17	(13.9) 47	(32.9) 72	(18.0) 36	(25.8) 108	(34.9) 153	(41.5) 172	(38.1) 325	(27.7) 259	(31.2) 225	(29.2) 484
Student	-	-	-	-	-	-	-	-	-	-	(3.1) 13	(1.5) 13	-	(1.8) 13	(0.8) 13
Total	(100.0) 27	(100.0) 21	(100.0) 48	(100.1) 251	(99.9) 87	(100.0) 338	(100.1) 219	(100.[illegible] 200	(100.1) 419	(100.0) 439	(99.9) 414	(100.0) 853	(100.1) 936	(100.0) 722	(100.0) 1658

TABLE 12 (cont.)

STAFF	(13)														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(3.1) 9	(0.7) 1	(2.3) 10	(8.6) 109	(6.3) 34	(7.9) 143	(6.4) 98	(11.1) 105	(8.2) 203	(4.0) 31	(0.7) 5	(2.4) 36	(6.4) 247	(6.2) 145	(6.3) 392
Other	(16.2) 47	(3.7) 5	(12.2) 52	(10.8) 137	(17.6) 95	(12.8) 232	(4.3) 65	(7.2) 68	(5.4) 133	(1.0) 8	(1.0) 7	(1.0) 15	(6.7) 257	(7.5) 175	(7.0) 432
Psychiatrist	(2.1) 6	(4.4) 6	(2.8) 12	(3.1) 39	(3.3) 18	(3.1) 57	(4.3) 65	(5.1) 48	(4.6) 113	(4.9) 38	(3.2) 23	(4.1) 61	(3.8) 148	(4.1) 95	(3.9) 243
Psychologist	(30.3) 88	(54.4) 74	(38.0) 162	(41.8) 531	(28.8) 155	(37.9) 686	(53.6) 815	(30.0) 283	(44.6) 1098	(60.6) 469	(47.7) 345	(54.3) 814	(49.4) 1903	(36.6) 857	(44.5) 2760
Social Worker	(43.8) 127	(33.1) 45	(40.4) 172	(29.5) 375	(39.9) 215	(32.6) 590	(25.5) 387	(40.2) 379	(31.1) 766	(25.7) 199	(43.1) 312	(34.1) 511	(28.2) 1088	(40.6) 951	(32.9) 2039
Student	(4.5) 13	(3.7) 5	(4.2) 18	(6.3) 80	(4.1) 22	(5.6) 102	(5.9) 90	(6.4) 60	(6.1) 150	(3.7) 29	(4.4) 32	(4.1) 61	(5.5) 212	(5.1) 119	(5.3) 331
Total	(100.0) 290	(100.0) 136	(99.9) 426	(100.1) 1271	(100.0) 539	(99.9) 1810	(100.0) 1520	(100.0) 943	(100.0) 2463	(99.9) 774	(100.1) 724	(100.0) 1498	(100.0) 3855	(100.1) 2342	(99.9) 6197

TABLE 12 (cont.)

STAFF	ROW TOTALS														
	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Nurses	(8.1) 36	(10.2) 31	(9.0) 67	(10.0) 311	(10.7) 114	(10.2) 425	(8.6) 368	(14.1) 359	(10.7) 727	(8.7) 302	(19.6) 827	(14.7) 1129	(9.0) 1017	(16.4) 1331	(12.1) 2348
Other	(11.8) 52	(6.6) 20	(9.6) 72	(5.4) 169	(10.2) 108	(6.6) 277	(2.7) 117	(4.3) 108	(3.3) 225	(3.2) 111	(4.4) 187	(3.9) 298	(4.0) 449	(5.2) 423	(4.5) 872
Psychiatrist	(7.7) 34	(11.8) 36	(9.4) 70	(7.5) 232	(5.9) 63	(7.1) 295	(8.8) 376	(11.6) 295	(9.9) 671	(21.3) 739	(15.4) 650	(18.1) 1389	(12.2) 1381	(12.8) 1044	(12.5) 2425
Psychologist	(34.4) 152	(45.6) 139	(39.0) 291	(57.9) 1798	(45.6) 485	(54.8) 2283	(56.4) 2411	(41.1) 1043	(50.7) 3454	(35.2) 1221	(20.0) 843	(26.8) 2064	(49.4) 5582	(30.9) 2510	(41.7) 8092
Social Worker	(32.6) 144	(22.6) 69	(28.5) 213	(15.6) 483	(24.4) 260	(17.8) 743	(20.6) 881	(24.9) 633	(22.2) 1514	(28.9) 1003	(37.8) 1598	(33.8) 2601	(22.2) 2511	(31.5) 2560	(26.1) 5071
Student	(5.4) 24	(3.3) 10	(4.6) 34	(3.6) 112	(3.2) 34	(3.5) 146	(2.8) 119	(3.9) 100	(3.2) 219	(2.7) 94	(2.8) 119	(2.8) 213	(3.1) 349	(3.2) 263	(3.2) 612
Total	(100.0) 442	(100.1) 305	(100.1) 747	(100.0) 3105	(100.0) 1064	(100.0) 4169	(99.9) 4272	(99.9) 2538	(100.0) 6810	(100.0) 3470	(100.0) 4224	(100.1) 7694	999.9) 11,289	(100.0) 8131	(100.1) 19,420

involved psychiatrists, but only 9.4 percent of contacts for the 0-4 year olds and 7.1 percent of the 5 to 9 year olds. Most of Nova Scotia's psychiatrists are general psychiatrists who are not trained specifically to deal with children (as opposed to adults). Many psychiatrists interviewed explained that they felt more comfortable working with adults and older adolescents than with children. This table suggests that as a result psychiatrists tend to see older adolescents and that other staff members tend to see the younger children.

Psychologists are involved in a larger proportion of contact with or for young people than are social workers for every age group except for the 15-19 year old group. These figures bear out the observation made during interview that many mental health facility medical directors and administrators seem to take for granted that social workers are the best qualified professionals for providing mental health services to adolescents. One might conclude that social worker training must generally include a special emphasis on adolescents, and that the training of psychiatrists and psychologists and other mental health professionals lacks this greater emphasis. There is no reason to believe that this is so, however.

Do the various types of mental health professional tend to spend different average amounts of time per contact? Table 13 shows that, while there is considerable variation among facilities, on the whole psychiatrists seem to spend the least amount of time per contact, followed closely by nurses and then social workers. Psychologists, on the whole, spend the largest amount of time per contact. In terms of proportion of total staff time contributed by the various professional groups, the results here are similar to those of table 12 (which dealt with the distribution of contacts per se rather than with staff time): psychiatrists account for 11.4 percent of total contact time, fractionally greater than the 11.2 percent accounted for by nurses and sharply less than the 43.6 percent for psychologists and 24.7 percent for the social workers.

TABLE 13

TOTAL CONTACT TIME AND AVERAGE TIME PER CONTACT BY TYPE OF STAFF INVOLVED, FOR 13 OUTPATIENT FACILITIES FOR THE 0 - 19 AGE GROUP, 1981.[1,2,3,4,5.]

	FACILITY									
	(01)		(02)		(03)		(04)		(05)	
STAFF	Total Time	Average Time Per Contact	Total Time	Average Time per Contact	Total Time	Average Time per Contact	Total Time	Average Time per Contact	Total Time	Average Time per Contact
	(9.0)		(7.0)		(13.4)		(18.6)		(8.9)	
Nurse	7,380.0	45.27	8,175.0	53.28	3,045.0	10.68	5,175.0	83.46	3,862.5	42.44
	(14.3)		(0.9)		(15.2)		(11.0)		(1.4)	
Other	11,745.0	53.63	997.5	58.67	3,450.0	56.55	3,060.0	52.75	600.0	22.22
	(50.4)		(11.6)		(27.4)		(37.1)		(7.0)	
Psychiatrist	41,475.0	58.99	13,605.0	44.17	6,217.5	36.57	10,312.5	46.66	3,030.0	31.09
	(0.6)		(69.3)		(3.6)		(8.3)		(55.9)	
Psychologist	487.5	60.93	81,225.0	74.24	810.0	67.50	2,295.0	71.71	24,367.5	53.20
	(17.3)		(11.3)		(24.7)		(23.3)		(26.8)	
Social Worker	14,765.0	51.49	13,222.5	42.51	5,617.5	34.04	6,472.5	44.63	11,685.0	34.06
	(8.4)		(0.04)		(15.8)		(1.7)		(0.09)	
Student	6,907.5	69.77	45.0	45.00	3,592.5	39.47	480.0	43.63	37.5	12.50
	(100.0)		(100.14)		(100.1)		(100.0)		(100.09)	
Total	82,260.0	55.99	117,270.0	62.27	22,732.5	34.33	27,795.0	52.54	43,582.5	42.85

TABLE 13 (cont.)

STAFF	FACILITY (06) Total Time	(06) Average Time per Contact	(07) Total Time	(07) Average Time per Contact	(08) Total Time	(08) Average Time per Contact	(09) Total Time	(09) Average Time per Contact	(10) Total Time	(10) Average Time Per Contact	(11) Total Time	(11) Average Time Per Contact
Nurse	(54.4) 31,447.5	56.76	(15.9) 11,347.5	84.68	(7.1) 1,995.0	28.91	(0.2) 90.0	45.00	(13.9) 5,205.0	39.13	(7.4) 3,622.5	32.93
Other	(0.1) 60.0	10.00	(2.7) 1,950.0	150.00	(0.8) 232.5	16.60			(1.9) 697.5	63.40		
Psychiatrist	(4.5) 2,610.0	41.42	(9.1) 6,472.5	45.58	(12.3) 3,487.5	59.11	(9.5) 3,757.5	30.54	(8.7) 3,247.5	32.15	(1.0) 510.0	63.75
Psychologist	(10.6) 6,150.0	62.12	(65.0) 46,267.5	41.53	(36.6) 10,350.0	44.42	(58.7) 23,265.0	47.57	(40.5) 15,142.5	54.86	(74.2) 36,097.5	41.44
Social Worker	(30.3) 17,535.0	55.31	(7.3) 5,167.5	62.25	(43.1) 12,187.5	54.65	(31.6) 12,532.5	41.09	(28.8) 10,762.5	51.99	(15.6) 7,575.0	45.63
Student									(6.3) 2,355.0	56.07	(1.7) 847.5	40.35
Total	(99.9) 57,802.5	55.63	(100.0) 71,205.0	47.91	(99.9) 28,252.5	47.24	(100.0) 39,645.0	43.13	(100.1) 37,410.0	48.58	(99.9) 48,652.5	41.37

TABLE 13 (cont.)

FACILITY

	(12)		(13)		Row Totals	
	Total Time	Average Time Per Contact	Total Time	Average Time Per Contact	Total Time	Average Time Per Contact
Nurse	(23.2) 10,822.5	33.50	(5.) 18,247.5	46.55	(11.2) 110,416.0	47.03
Other	(0.3) 157.5	11.25	(8.1) 29,722.5	68.00	(5.3) 52,872.5	60.40
Psychiatrist	(9.1) 4,230.0	22.30	(3.9) 14,130.0	58.15	(11.4) 113,005.0	46.63
Psychologist	(41.3) 19,245.0	30.35	(45.4) 165,832.5	60.08	(43.6) 431,535.0	53.41
Social Worker	(24.6) 11,437.5	23.63	(31.7) 116,010.0	56.90	(24.7) 244,470.0	48.20
Student	(1.5) 690.0	53.07	(5.9) 21,510.0	60.98	(3.7) 36,465.0	59.58
Total	(100.0) 46,582.5	28.11	(100.0) 365,452.5	59.15	(99.9) 988,642.5	50.96

1. Time is given in minutes.
2. More than one staff member may be involved in a contact, so the total of all staff contacts for each facility is greater than the actual number of contacts which occurred from the patients' point of view.
3. Calculated on the basis of staff contact.
4. Numbers in brackets are percentages of column totals.
5. Contact time means with patients or on behalf of patients.

Table 14 continues the discussion of contacts and contact time, emphasizing not type of staff involved but rather the age of patient/client. Once again, there is great variability in total amount of staff time devoted to an individual, variability both by facility and by age of patient/client. One facility, for example, averaged 148.92 minutes total staff time spent on each patient's/clients's behalf, while another averaged 498.9 minutes per patient/client. There was little consistency, as well, as to which age group received the longest average amount of staff time. Facility 05, for example, spent its longest length of time with the 15-19 age group (197.1 minutes).

A number of facilities revealed weakness in their services to the younger age groups by seeing the 0-4 and (to a lesser extent) 5-9 age groups for both fewer contacts and for a lower average total time than they devoted to the older age groups. However it should be noted that this table is based on data contained in the contact forms and excludes information from the outpatient registration form. Since (except for a single facility) a contact form is not usually filled out until a second visit, if any, the table systematically underestimates the actual total amount of time devoted to any single patient/client. Thus, for facility 05, the average time spent on a patient's/client's behalf is not really 1.88 minutes, it is 1.88 minutes plus the average length of the initial (registration) visit. (It proved impossible for the Department of Health's computer system to add time from the registration forms to time from the contact forms in order to correct this difficulty.)

Since contacts need not necessarily involve the patient, and then not necessarily the patient alone, it is useful to see just who is interviewed in a contact. Table 15 compares the 0-9 and 10-19 age groups in terms of who gets interviewed, for all Nova Scotia outpatient mental health facilities. Not surprisingly, for the 0-9 group 21.1 percent of the interviews involve the patient only, while for the 10-19 group that figure was 47.5 percent. In similar fashion, the family as well as the patient is involved in 46.7 percent of contacts with the 0-9 group, but

TABLE 14

AVERAGE CONTACT TIME AND NUMBER OF CONTACTS PER OUTPATIENT FOR THIRTEEN FACILITIES BY AGE GROUPS, 1981.

FACILITY	AGE GROUP						
	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19	20+	TOTAL
(01)							
# of patients	38	127	192	127	484	6	490
Average # of contacts per patient	2.26	2.04	2.45	3.94	2.72	0.83	2.69
Average time per contact[1]	50.84	58.23	57.30	51.21	54.75	105.00	54.93
Average time spent on patient's behalf[1]	114.90	118.79	140.39	201.77	148.92	87.15	147.76
(02)							
# of patients	7	40	82	104	233	803	1036
Average # of contacts per patient	9.86	7.33	9.46	7.04	8.03	7.00	7.23
Average time per contact	45.21	71.33	57.56	54.27	62.13	38.61	44.48
Average time spent on patient's behalf	445.77	522.85	539.12	382.06	498.90	270.27	321.59
(03)							
# of patients			1	85	86	1328	1414
Average # of contacts per patient			20.00	6.12	6.28	10.39	10.14
Average time per contact			23.25	33.00	32.54	32.31	32.32
Average time spent on patient's behalf			465.00	201.96	204.38	335.70	327.72
(04)							
# of patients	1	10	38	145	194	1143	1337
Average # of contacts per patient	1.00	0.10	0.37	2.70	2.20	7.95	7.12
Average time per contact	150.00	7.50	38.40	43.20	43.00	35.23	35.58
Average time spent on patient's behalf	150.00	0.75	33.41	116.54	94.50	280.08	253.23
(13)							
# of patients	121	339	383	213	1056	5	1061
Average # of contacts per patient	3.12	4.50	5.38	6.32	5.04	4.30	5.04
Average time per contact	56.38	53.82	55.36	54.39	57.17	55.83	57.16
Average time spent on patient's behalf	207.73	254.89	311.70	328.83	238.14	257.02	288.09

TABLE 14 (cont.)

FACILITY	AGE GROUP 0 - 4	5 - 9	10 - 14	15 - 19	0 - 19	20+	TOTAL
(05)							
# of patients	8	67	68	116	259	1423	1682
Average # of contacts per patient	0.25	2.40	3.68	4.59	3.65	7.89	7.23
Average time per contact	7.50	33.91	45.42	42.94	41.99	34.59	35.17
Average time spent on patient's behalf	1.88	81.38	167.15	197.09	153.26	272.92	254.29
(06)							
# of patients	9	29	42	82	162	351	513
Average # of contacts per patient	3.22	8.34	6.86	5.30	6.14	6.29	6.24
Average time per contact	60.00	55.56	54.50	54.24	54.81	46.31	48.95
Average time spent on patient's behalf	193.20	463.37	373.87	287.47	336.53	291.29	305.45
(07)							
# of patients	3	30	52	53	138	661	799
Average # of contacts per patient	3.00	14.03	11.75	5.87	9.80	4.91	5.76
Average time per contact	19.16	31.12	46.75	49.96	42.44	50.38	48.05
Average time spent on patient's behalf	57.48	436.51	549.31	293.27	415.91	247.37	276.77
(08)							
# of patients	3	8	48	69	128	440	568
Average # of contacts per patient	3.00	4.88	3.75	5.12	4.54	5.82	5.53
Average time per contact	30.83	63.46	41.54	48.69	47.19	41.25	42.84
Average time spent on patient's behalf	92.49	309.62	155.78	249.29	214.24	243.57	236.91
(09)							
# of patients	15	65	92	87	259	663	922
Average # of contacts per patient	1.60	2.22	3.78	4.51	3.51	5.71	5.09
Average time per contact	28.75	44.47	44.51	42.14	43.11	39.03	39.92
Average time spent on patient's behalf	46.00	98.72	166.53	190.05	151.32	222.86	202.58

TABLE 14 (cont.)

FACILITY	AGE GROUP						
	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19	20+	TOTAL
(10)							
# of patients	11	67	124	148	350	1237	1587
Average # of contacts per patient	0.82	0.85	1.85	2.51	1.90	4.61	4.02
Average time per contact	49.16	51.57	49.55	44.45	46.91	35.39	36.50
Average time spent on patient's behalf	40.31	43.83	91.85	111.57	89.13	163.15	147.13
(11)							
# of patients	8	59	80	69	226	330	556
Average # of contacts per patient	1.38	4.62	6.44	4.77	5.19	4.90	5.02
Average time per contact	50.68	41.51	40.47	41.69	41.31	48.92	45.72
Average time spent on patient's behalf	83.74	192.24	250.53	198.86	214.40	239.71	229.51
(12)							
# of patients	17	67	71	125	280	904	1184
Average # of contacts per patient	2.71	5.03	5.90	6.32	5.91	7.31	7.44
Average time per contact	34.72	30.02	27.79	27.12	28.10	22.22	23.32
Average time spent on patient's behalf	94.09	151.00	163.96	184.36	166.07	175.76	173.50

TABLE 15 CONTACT INTERVIEWEE, BY AGE GROUP, FOR ALL OUTPATIENT MENTAL HEALTH FACILITIES, 1981.[1]

INTERVIEWEE		ROW TOTALS	
	0 - 9	10 - 19	0 - 19
Patient Only	(21.1) 772	(47.5) 5625	(41.3) 6397
Patient and Family	(46.7) 1707	(25.5) 3020	(30.5) 4727
School	(17.6) 642	10.6) 1255	(12.2) 1897
Physician	(1.9) 70	(1.8) 217	(1.9) 287
Referring Agent	(1.8) 67	(2.0) 237	(2.0) 304
Social Agency	(5.2) 191	(6.2) 734	(6.0) 925
Proprietor	(0.3) 10	(0.4) 47	(0.4) 57
Other	(5.3) 194	(6.0) 714	(5.9) 908
Total	(99.9) 3653	(100.0) 11,849	(100.2) 15,502

1. Numbers in brackets are percentages of column totals.

only 25.5 percent of contacts with the 10-19 age group. Somewhat surprising is the finding that regardless of age group, the proportion of contacts involving the young person's physician is less than 2 percent. In short, it is clear that it is unusual for the family physician to play a substantial role in the treatment plan.

Many mental health facilities explain that they use a "team" approach. As has previously been discussed, from the staff point of view there are more contacts than there are from the patient/client point of view, since more than one staff member may see a client/patient at the same time. To what extent does the claim that a facility uses a "team" approach reveal itself in more than one staff member seeing a patient simultaneously during a contact? The answer is that the vast majority of contacts for all facilities involve only a single staff member. For the 13 facilities here surveyed, table 16 shows that 1.09 staff members on the average were involved in a contact. The range is from 1.24 to 1.03. It is, of course, possible that during initial assessments rather than subsequent contacts it is more common for two or more staff members to see a patient/client together.

For how many weeks or months are patients/clients seen by mental health facilities? Table 17 attempts to answer this question for eleven mental health facilities, for 1981. Note, however, that these data are of quite poor quality, given the earlier discussion of frequent discrepancies between when the Department of Health's computer system considers a case closed and when it is so considered by the facility providing treatment. The figures provided by that computer system show, on the average, 81.6 days elapsed between opening and closing a case for the 0-9 year old group, and 94.6 days for the 10-19 age group. Though the precision of these figures is certainly questionable, it does seem probable that the cases of young patients/clients are on the whole kept open for considerably longer than those of older individuals. Variation from one facility to another, as shown in table 17, is great but of unclear validity (given varying practices in the ways in which records are kept).

TABLE 16: AVERAGE NUMBER OF STAFF INVOLVED PER OUTPATIENT CONTACT, BY AGE GROUP, FOR THIRTEEN FACILITIES, 1981.$^{1, 2.}$

AGE GROUP	(01) # of staff contact	(01) # of patient contact	(01) Average # of staff involved per contact	(02) # of staff contact	(02) # of patient contact	(02) Average # of staff involved per contact	(03) # of staff contact	(03) # of patient contact	(03) Average # of staff involved per contact	(04) # of staff contact	(04) # of patient contact	(04) Average # of staff involved per contact
0 - 4	105	86	1.22	69	69	1.00	-	-	-	1	1	1.00
5 - 9	313	259	1.21	293	293	1.00	-	-	-	1	1	1.00
10 - 14	531	470	1.13	779	776	1.00	28	20	1.40	39	33	1.18
15 - 19	520	500	1.04	742	732	1.01	634	520	1.22	488	392	1.24
0 - 19	1469	1315	1.12	1883	1870	1.01	662	540	1.23	529	427	1.24
20 +	8	5	1.60	5809	5621	1.03	17,305	13,794	1.25	10,225	9,086	1.13
Total	1477	1320	1.12	7692	7491	1.03	17,967	14,334	1.25	10,784	9,513	1.13

Table 16 (cont.)

AGE GROUP	(05) # of staff contact	(05) # of patient contact	(05) Average # of staff involved per contact	(06) # of staff contact	(06) # of patient contact	(06) Average # of staff involved per contact	(07) # of staff contact	(07) # of patient contact	(07) Average # of staff involved per contact	(08) # of staff contact	(08) # of patient contact	(08) Average # of staff involved per contact
0 - 4	2	2	1.00	30	29	1.03	9	9	1.00	9	9	1.00
5 - 9	165	161	1.02	253	242	1.05	421	421	1.00	39	39	1.00
10 - 14	260	250	1.04	305	288	1.06	654	611	1.07	188	180	1.04
15 - 19	590	533	1.11	451	435	1.04	402	311	1.29	362	353	1.03
0 - 19	1,017	946	1.08	1,039	994	1.05	1,486	1,352	1.10	598	581	1.03
20 +	13,075	11,222	1.17	2,266	2,207	1.03	4,139	3,247	1.27	2,837	2,560	1.11
Total	14,092	12,168	1.16	3,305	3,201	1.03	5,625	4,599	1.22	3,435	3,141	1.09

Table 16 (cont.)

	(09)			(10)			(11)			(12)		
AGE GROUP	# of staff contact	# of patient contact	Average # of staff involved per contact	# of staff contact	# of patient contact	Average # of staff involved per contact	# of staff contact	# of patient contact	Average # of staff involved per contact	# of staff contact	# of patient contact	Average # of staff involved per contact
0 - 4	24	24	1.00	12	9	1.33	11	11	1.00	47	46	1.02
5 - 9	146	144	1.01	66	57	1.16	319	319	1.00	338	337	1.00
10 - 14	356	348	1.02	265	229	1.16	515	515	1.00	419	419	1.00
15 - 19	393	392	1.00	427	371	1.15	331	329	1.01	853	853	1.00
0 - 19	919	908	1.01	770	666	1.16	1,176	1,174	1.00	1,657	1,655	1.00
20 +	3,857	3,783	1.02	6,373	5,707	1.12	1,618	1,617	1.00	7,193	7,152	1.01
Total	4,776	4,691	1.02	7,143	6,373	1.12	2,794	2,791	1.00	8,850	8,807	1.00

Table 16 (cont.)

	(13)			ROW TOTALS		
AGE GROUP	# of staff contact	# of patient contact	Average # of staff involved per contact	# of staff contact	# of patient contact	Average # of staff involved per contact
0 - 4	426	377	1.13	745	672	1.11
5 - 9	1,810	1,527	1.19	4,164	3,000	1.10
10 - 14	2,463	2,136	1.15	6,002	6,275	1.08
15 - 19	1,498	1,283	1.17	7,691	7,004	1.10
0 - 19	6,196	5,323	1.16	19,401	17,751	1.09
20 +	26	24	1.08	74,761	66,025	1.13
Total	6,223	5,347	1.16	94,162	83,776	1.12

1. "Contact" means a contact (in person or by telephone) either with or on behalf of a patient or client.

2. "Staff contact" means a contact from a staff member's point of view. Since more than one staff member may see a patient simultaneously, the total of staff contacts will be greater than the total of patient contacts (contacts from the point of view of the patient).

Table 17: Average Number of Days Between Outpatient Registration and Case Closure, by Age Group, for 11 Mental Health Facilities, 1981.

	(01)			(02)			(03)			(04)			(05)		
	0-9	10-19	0-19	0-9	10-19	0-19	0-9	10-19	0-19	0-9	10-19	0-19	0-9	10-19	0-19
Number of days	2966	5446	8412	7	84	91	525	2134	2659	14	1220	1234	902	1280	2182
Number of cases closed	38	66	104	2	1	3	1	7	8	1	13	14	7	12	19
Average number of days between registration and case closure	78.1	82.5	80.9	3.5	84.0	30.3	525.0	304.9	332.4	14.0	93.8	88.1	128.9	106.7	114.8

Table 17 (cont.)

	(07)			(08)			(09)			(11)			(12)		
	0-9	10-19	0-19	0-9	10-19	0-19	0-9	10-19	0-19	0-9	10-19	0-19	0-9	10-19	0-19
Number of days	196	535	731	318	1372	1690	3203	5192	8395	1681	3040	4721	2247	7572	9819
Number of cases closed	2	3	5	2	16	18	26	46	72	11	34	45	33	92	125
Average number of days between registration and case closure	98.0	178.3	146.2	169.0	85.8	93.9	123.2	112.9	116.6	152.8	89.4	104.9	68.1	82.3	78.6

Table 17 (cont.)

	(13)			ROW TOTALS		
	0-9	10-19	0-19	0-9	10-19	0-19
Number of days	3426	7570	10,996	15,485	35,445	50,930
Number of cases closed	42	80	122	165	370	535
Average number of days between registration and case closure	81.6	94.6	90.1	93.8	95.8	95.2

Table 18 addresses itself to the topic of where outpatient contacts usually take place. After all, most Nova Scotian mental health facilities have community mental health nurses on their staff whose duties include out-reach work. However, if we add contacts taking place at the mental health facility itself to contacts made by telephone we find that these account for over 90 percent of all outpatient mental health contacts for the 0-19 age group for the entire Province. Though many facilities during interview espoused the notion that one must have contact with a young person's school, home and general social situation in order to understand his/her problem, mental health facilities are only occasionally gathering such data directly.

We have already seen that the total amount of staff time received by an individual patient/client is in part dependent on his/her age and in part on the profession of the mental health staff member who is the principal therapist. Surely, however, the patient/client's diagnostic category must have important implications for the amount of treatment needed. Table 19 addresses this question. The diagnostic categories it uses are from the "Ninth Revision of the International Classification of Diseases" (ICD-9), chapter V ("Mental Disorders"). For those concerned with the issue of "cost effectiveness" (discussed in chapter VII's treatment of "priorities"), this table's data on the relative cost in terms of staff time of particular diagnostic categories must be of some interest.

Some diagnostic categories are clearly more expensive in terms of staff time, on the average, than are others. For the 0-4 age group, the "special symptoms" category requires an average of 270 minutes of staff time, while mental retardation requires only 13.5 minutes. However, the number of patients/clients involved here is quite low (presumably because most mental retardation patients are seen for assessment only), rendering the averages unstable. Moving to the 5-9 age group the largest amount of staff time is taken up by childhood psychoses (507.19 minutes on average), while the least amount of time is taken up by physiological malfunction from mental factors and psychic factors associated with other (non-mental disorder) diseases (50.63 minutes).

TABLE 18

LOCATION OF OUTPATIENT CONTACT, BY AGE GROUP AND FACILITY, FOR 1981.[1,2]

	(01)			(02)			(03)			(04)		
LOCATION OF CONTACT	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19
0. At Centre	(90.4) 312	(95.5) 926	(94.1) 1238	(69.4) 252	(70.0) 1056	(69.9) 1308	(100.0) 7	(51.9) 280	(52.5) 287	(81.8) 18	(63.8) 271	(64.7) 289
1. Home				(1.1) 4	(0.9) 13	(0.9) 17		(0.4) 2	(0.4) 2		(3.3) 4	(3.1) 4
2. School		(0.1) 1	(0.1) 1	(0.3) 1	(1.3) 20	(1.1) 21		(0.2) 1	(0.2) 1		(0.2) 1	(0.2) 1
3. Hospital	(9.3) 32	(4.2) 41	(5.6) 73	(2.5) 9	(2.8) 42	(2.7) 51		(12.4) 67	(12.2) 67		(1.4) 6	(1.3) 6
4. Institution					(0.1) 2	(0.1) 2					(0.7) 6	(0.7) 6
5. Telephone Only	(0.3) 1	(0.1) 1	(0.2) 2	(6.6) 24	(10.7) 161	(9.9) 185		(34.8) 188	(34.4) 188	(18.2) 4	(23.3) 99	(23.0) 103
9. Other		(0.1) 1	(0.1) 1	(20.1) 73	(14.2) 214	(15.3) 287		(0.4) 2	(0.4) 2		(7.3) 31	(6.9) 31
Total	(100.1) 345	(100.0) 970	(100.1) 1315	(100.0) 363	(100.0) 1508	(99.9) 1871	(100.0) 7	(100.1) 540	(100.1) 547	(100.0) 22	(100.0) 425	(99.9) 447

TABLE 18 (cont.)

FACILITY

	(05)			(06)			(07)			(08)		
LOCATION OF CONTACT	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19
0. At Centre	(37.7) 63	(73.6) 576	(67.3) 639	(63.5) 181	(75.9) 549	(72.4) 730	(20.2) 93	(55.5) 512	(43.8) 605	(70.0) 35	(68.9) 367	(69.0) 402
1. Home	(3.0) 5	(0.3) 2	(0.7) 7	(5.3) 15	(2.1) 15	(3.0) 30	(8.7) 40	(4.6) 42	(5.9) 82	(22.0) 11	(5.6) 30	(7.0) 41
2. School	(4.2) 7	(1.3) 10	(1.8) 17	(2.1) 6	(1.5) 11	(1.7) 17	(15.2) 70	(4.8) 44	(8.2) 114		(12.2) 65	(11.1) 65
3. Hospital		(0.1) 1	(0.1) 1	(1.1) 3	(1.1) 8	(1.1) 11	(2.4) 11	(0.3) 3	(1.0) 14	(4.0) 2	(0.9) 5	(1.2) 7
4. Institution		(0.1) 1	(0.1) 1	(0.4) 1	(2.4) 17	(1.8) 18					(0.6) 3	(0.5) 3
5. Telephone Only	(55.1) 92	(24.4) 191	(29.8) 283	(26.0) 74	(16.0) 116	(18.8) 190	(49.8) 229	(31.1) 287	(37.3) 516	(4.0) 2	(10.9) 58	(10.3) 60
9. Other		(0.3) 2	(0.2) 2	(1.8) 5	(1.0) 7	(1.2) 12	(3.7) 17	(3.7) 34	(3.7) 51		(0.9) 5	(0.9) 5
Total	(100.0) 167	(100.1) 783	(100.0) 950	(100.2) 285	(100.0) 723	(100.0) 1008	(100.0) 460	(100.0) 922	(99.9) 1382	(100.0) 50	(100.0) 533	(100.0) 583

TABLE 18 (cont.)

	FACILITY											
	(09)			(10)			(11)			(12)		
LOCATION OF CONTACT	0 - 9.	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19
	(54.2)	(76.4)	(70.7)	(65.8)	(71.5)	(70.8)	(61.5)	(67.4)	(65.8)	(63.6)	(52.7)	(55.3)
0. At Centre	137	565	702	52	429	481	203	569	772	260	670	930
	(5.1)	(1.1)	(2.1)	(7.6)	(7.0)	(7.1)	(0.3)	(1.2)	(0.9)	(1.7)	(3.9)	(3.4)
1. Home	13	8	21	6	42	48	1	10	11	7	50	57
	(6.3)	(4.5)	(4.9)	(6.3)	(2.5)	(2.9)	(7.3)	(2.4)	(3.7)	(1.0)	(9.0)	(7.0)
2. School	16	33	49	5	15	20	24	20	44	4	114	118
	(26.5)	(7.7)	(12.5)	(1.3)	(0.7)	(0.7)	(0.3)	(0.7)	(0.6)	(0.2)	(0.2)	(0.2)
3. Hospital	67	57	124	1	4	5	1	6	7	1	2	3
	(0.8)		(0.2)		(1.0)	(0.9)		(0.1)	(0.1)		(0.3)	(0.2)
4. Institution	2		2		6	6		1	1		4	4
	(4.7)	(10.0)	(8.7)	(13.9)	(16.7)	(16.3)	(30.3)	(27.5)	(28.3)	(33.5)	(32.4)	(32.7)
5. Telephone Only	12	74	86	11	100	111	100	232	332	137	412	549
	(2.4)	(0.4)	(0.9)	(5.1)	(0.7)	(1.2)	(0.3)	(0.7)	(0.6)		(1.6)	(1.2)
9. Other	6	3	9	4	4	8	1	6	7		20	20
	(100.0)	(100.1)	(100.0)	(100.0)	(100.1)	(99.9)	(100.0)	(100.0)	(100.0)	(100.0)	(100.1)	(100.0)
Total	253	740	993	79	600	679	330	844	1174	409	1272	1681

TABLE 10 (cont.)

	FACILITY (13)			ROW TOTALS		
LOCATION OF CONTACT	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19
0. At Centre	(81.0) 1543	(82.3) 2814	(81.9) 4357	(67.5) 3156	(72.2) 9584	(71.0) 12,740
1. Home	(4.8) 91	(1.2) 41	(2.5) 132	(4.1) 193	(2.0) 269	(2.6) 462
2. School	(1.5) 29	(2.0) 69	(1.8) 98	(3.5) 162	(3.0) 404	(3.2) 566
3. Hospital	-	(0.4) 13	(0.2) 13	(2.7) 127	(1.9) 256	(2.1) 382
4. Institution	(0.2) 3	(0.1) 4	(0.1) 7	(0.1) 6	(0.3) 41	(0.3) 47
5. Telephone Only	(12.1) 230	(13.5) 462	(13.0) 692	(19.6) 916	(17.9) 2381	(18.4) 3297
9. Other	(0.4) 8	(0.5) 16	(0.5) 24	(2.4) 114	(2.6) 345	(2.6) 459
Total	(100.0) 1904	(100.0) 3419	(100.0) 5323	(99.9) 4674	(99.9) 13,279	(100.2) 17,953

1. Numbers in brackets are percentages of column totals.
2. A contact may be either with or on behalf of a patient.

TABLE 19' Average Total Staff Time per Patient, by Age Group and Latest Diagnosis, for all Age 0-19 Psychiatric Outpatients, 1981, 1, 2, 3.

Diagnosis	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
	Total staff time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient	Total staff Time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient
Neurotic Disorders 300	2797.50	17	164.56	5070.00	28	181.07	14,040.00	69	203.48	38,302.50	124	308.89	60,210.00	238	252.98
Psychoses (schizophrenia, affective psychoses, paranoid states). 295, 296, 297.	982.50	12	81.88	555.00	2	277.50	982.50	4	245.63	11,932.50	48	248.59	14,452.50	66	218.98
Other Non-Organic Psychoses 298	82.50	3	27.50	-	-	-	120.00	1	120.00	1350.00	5	270.00	1552.50	9	172.50
Childhood Psychoses 299	-	1	-	4057.50	8	507.19	660.00	3	220.00	-	1	-	4717.50	13	362.88
Alcohol & Other Drug Abuse, Dependence & Psychoses. 291, 292, 293, 303, 304, 305.	-	-	-	-	-	-	22.50	6	3.75	1972.50	23	85.76	1995.00	29	68.79
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa. 307	1080.00	4	270.00	3990.00	25	159.60	3780.00	29	130.34	6435.00	20	321.75	15,285.00	78	195.96
Acute Reaction to Stress. Adjustment Reaction. 308, 309.	14,767.50	83	177.92	55,867.50	314	177.92	91,950.00	398	231.03	113,977.50	512	222.61	276,562.50	1307	211.60
Organic Psychotic Conditions. Non-psychotic disorders following brain damage. 294, 310.	112.50	7	16.07	-	-	-	1837.50	2	918.75	1965.00	8	245.63	3915.00	17	230.29

Table 19 (cont.)

Diagnosis	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
	Total staff time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient	Total staff Time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient
Sexual Deviations and Disorders. 302.	-	-	-	-	-	-	90.00	1	90.00	2010.00	9	223.33	2100.00	10	210.00
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified. 306, 316.	-	-	-	202.50	4	50.63	10,725.00	11	975.00	5377.50	11	488.86	16,305.00	26	627.12
Depressive Disorder. 311.	855.00	7	122.14	-	1	-	1845.00	9	205.00	7035.00	30	234.50	9735.00	47	207.13
Conduct Disorder. 312.	1837.50	22	83.52	33,345.00	123	271.10	56,932.50	224	254.16	32,527.50	174	186.94	124,642.50	543	229.54
Disturbance of emotions specific to childhood and adolescence. 313	217.50	4	54.38	5182.50	30	172.75	9720.00	43	226.05	1680.00	20	84.00	16,800.00	97	173.20
Hyperkinesis. 314	1867.50	14	133.39	12,570.00	33	380.91	9735.00	20	486.75	157.50	3	52.50	24,330.00	70	347.57
Developmental Delays. 315	1687.50	17	99.26	17,257.50	76	227.07	27,000.00	86	313.95	4455.00	29	153.62	50,400.00	208	242.31
Mental Retardation. 317, 318, 319.	67.50	5	13.50	3855.00	31	124.35	12,375.00	29	426.72	7432.50	42	176.96	23,730.00	107	221.78

Table 19 (cont.)

	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
Diagnosis	Total staff time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient	Total staff time	# of patients	Ave. total staff time per patient
Personality Disorder 301	922.50	5	184.50	97.50	2	48.75	6,195.00	17	364.41	23,002.50	128	179.71	30,217.50	152	198.80
Other	16,065.06	105	153.00	50,827.50	245	207.46	76,117.50	328	232.07	61,552.50	253	243.29	204,562.50	911	219.72
Total	43,342.50	306	141.64	192,877.50	922	209.19	324,127.50	1,280	253.22	321,165.00	1,440	223.03	881,512.50	3948	223.28

1. Time is in minutes.

2. Data were supplied by the Department of Health.

3. Since initial diagnoses may be changed on a contact form, the Department of Health keeps a file on the most recent diagnosis for each patient. These patients can be 1981 registrants or registrants from the previous year who are still being treated. Thus in this table the number of patients in each diagnostic category is larger than if diagnoses had been obtained only from 1981 registration forms.

But physiological malfunction from mental factors and psychic factors associated with disease change position when we move to the 10-14 age group, here accounting for the largest average amount of time (averaging 975.00 minutes). The diagnostic category which for this age group requires the least amount of staff time is "alcohol and other drug abuse, dependence and psychoses" (3.75 minutes). The numbers of individuals involved are, however, so low as to render the "average" unstable. The 15-19 age group shares with their 10-14 year old fellow patients/clients the tendency, on the average, for "physiological malfunction from mental factors" and "psychic factors associated with diseases elsewhere classified" to take up more staff time than other diagnoses (488.86 minutes). The category which takes up the least amount of staff time is hyperkinesis, though once again the small number of patients/clients makes the average unreliable.

The groupings into which diagnostic categories have been collapsed, while necessary to keep the table of manageable size, are not necessarily the most effective to use for purposes of calculating the amount of time each kind of problem requires of mental health staff. Another difficulty is that the tendency for some diagnoses to be made only occasionally distorts certain of the averages, as was noted above. Finally, the large number of "other" diagnoses suggests that mental health staff are frequently unwilling or unable to make a diagnosis in the first place. In some cases, mental health staff apparently believe that a diagnosis will "label" a child and, by predjudicing the expectations of others, harm him/her. It is possible that a table similar to table 19 but utilizing presenting problems rather than diagnostic category might be of more use in future planning.

It is certainly quite likely that a very small percentage of patients/clients take up a disproportionate amount of staff time. While Department of Health records do not permit us to confirm this surmise, the Atlantic Child Guidance Centre reports that, for its Halifax branch, 2 percent of patients took up 11.5 percent of staff time in 1978; 1.2 percent of patients took up 8.8 percent of staff time in 1979; 1.0 percent of patients took up 8.2 percent of staff time in 1980; and 3.6 percent of patients took up 17.5 percent of staff time in 1981.

Table 19 also tell us, apart from specific diagnoses, the average amount of staff devoted to the various age groups. The 0-4 age group averages 141.64 minutes of staff time, the 5-9 age group averages 209.19 minutes, the 10-14 age group 253.22 minutes, and the 15-19 group 223.03 minutes. In general, then, the 0-4 age group receives far less staff time than do the older age categories.

What kind of treatment do young mental health outpatients receive in Nova Scotia? Table 20 uses the outpatient contact forms and their categories to answer this question. Since the table combines general mental health facilities with those specializing in young people, it is not surprising that it reveals great variability in treatments offered. But it is important to note that many facilities offer little or no group therapy and play therapy. The former is believed by many mental health professionals to be of particular importance in the treatment of adolcescents, while experts in children's mental health suggested that lack of play therapy is likely to reflect a lack of commitment to providing is likely to reflect a lack of commitment to providing treatment for young children on the part of a facility.

As one would expect, parent therapy and family therapy tend to be more important for the younger children than for the older adolescents, who tend to receive individual therapy. Chemotherapy and electroconvulsive therapy are both used quite rarely, the latter occurring in only a handful of cases. Behaviour therapy -- the effort to modify behaviour by altering the pattern of rewards and sanctions an individual receives in his/her daily life — is little more frequent than chemotherapy. This is a surprising finding, both because behaviour therapy is considered by most mental health professionals frequently to be of considerable benefit and because it tends to be associated with pyschologists (who, as we have seen, provide a major share of therapy in most mental health centres).

TABLE 20 Type of Treatment, by Age Group and Sex, for Thirteen Outpatient Mental Health Facilities, 1981.[1]

(01)

	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
TYPE OF TREATMENT	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
	(23.4)	(34.4)	(29.6)	(24.4)	(22.2)	(23.9)	(31.2)	(41.9)	(36.5)	(56.6)	(64.2)	(62.2)	(33.6)	(50.6)	(42.7)
1. Individual Therapy	11	21	32	65	20	85	99	130	229	90	294	384	265	465	730
	(17.0)	(8.2)	(12.0)	(15.0)	(10.9)	(16.0)	(19.2)	(8.7)	(14.0)	(6.3)	(9.4)	(8.6)	(15.1)	(10.0)	(12.4)
2. Parent Therapy	8	5	13	40	17	57	61	27	88	10	43	53	119	92	211
	(38.3)	(6.6)	(20.4)	(29.7)	(26.7)	(28.9)	(19.2)	(20.6)	(19.9)	(5.0)	(8.7)	(7.8)	(21.0)	(14.4)	(17.4)
3. Family Therapy	18	4	22	79	24	103	61	64	125	8	40	48	166	132	298
				(0.4)		(0.3)					(0.4)	(0.3)	(0.1)	(0.2)	(0.2)
4. Group Therapy	-	-	-	1	-	1	-	-	-	-	2	2	1	2	3
		(3.3)	(1.9)	(4.9)	(5.6)	(5.1)		(3.2)	(1.6)				(1.6)	(1.8)	(1.8)
5. Play Therapy	-	2	2	13	5	18	-	10	10	-	-	-	13	17	30
		(8.2)	(4.6)	(3.4)		(2.5)	(4.1)	(0.6)	(2.4)	(10.7)	(4.4)	(6.0)	(4.9)	(2.9)	(3.9)
6. Chemotherapy	-	5	5	9	-	9	13	2	15	17	20	37	39	27	66
							(0.3)		(0.2)				(0.1)		(0.1)
7. E.C.T.	-	-	-	-	-	-	1	-	1	-	-	-	1	-	1
	(2.1)	(8.2)	(5.6)	(1.9)	(7.8)	(3.4)	(2.8)	(5.5)	(4.1)	(2.5)	(2.2)	(2.3)	(2.4)	(4.2)	(3.4)
8. Behavior Therapy	1	5	6	5	7	12	9	17	26	4	10	14	19	39	58
				(0.4)	(2.2)	(0.8)	(0.9)		(0.5)		(0.7)	(0.5)	(0.5)	(0.5)	(0.5)
9. Marital Therapy	-	-	-	1	2	3	3	-	3	-	3	3	4	5	9
	(4.3)	(1.6)	(2.8)	(0.8)	(1.1)	(0.8)	(0.6)	(1.9)	(1.3)		(1.3)	(1.0)	(0.8)	(1.5)	(1.2)
10. Other	2	1	3	2	1	3	2	6	8	-	6	6	6	14	20
	(8.5)	(13.1)	(11.1)	(15.0)	(10.0)	(13.8)	(16.1)	(11.0)	(13.6)	(9.4)	(5.0)	(6.2)	(13.9)	(8.1)	(10.8)
12. Assessment	4	8	12	40	9	49	51	34	85	15	23	38	110	74	184
	(6.4)	(16.4)	(12.0)	(4.1)	(5.6)	(4.5)	(5.4)	(6.5)	(5.9)	(9.4)	(3.7)	(5.2)	(5.8)	(5.7)	(5.7)
13. Counselling	3	10	13	11	5	16	17	20	37	15	17	32	46	52	98
	(100.0)	(100.0)	(100.0)	(100.0)	(100.1)	(100.0)	(99.8)	(99.9)	(100.0)	(99.9)	(100.0)	(100.1)	(99.8)	(99.9)	(100.1)
TOTAL	47	61	108	266	90	356	317	310	627	159	450	617	789	919	1708

TABLE 20 (cont.)

(02)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	(28.6) 2	(11.6) 11	(12.7) 13	(10.2) 46	(28.8) 17	(12.4) 63	(19.8) 132	(22.0) 126	(20.8) 258	(30.6) 154	(30.5) 140	(30.5) 294	(20.5) 334	(24.8) 294	(22.3) 628
2. Parent Therapy	(14.3) 1	(15.8) 15	(15.7) 16	(10.2) 46	(6.8) 4	(9.8) 50	(1.4) 9	(1.6) 9	(1.5) 18	(0.6) 3	(0.9) 4	(0.7) 7	(3.6) 59	(2.7) 32	(3.2) 91
3. Family Therapy	(14.3) 1	(6.3) 6	(6.9) 7	(1.8) 8	(5.1) 3	(2.2) 11	(2.1) 14	(2.1) 12	(2.1) 26	(3.6) 18	(4.4) 20	(3.9) 38	(2.5) 41	(3.5) 41	(2.9) 82
4. Group Therapy	-	(1.1) 1	(1.0) 1	(17.1) 77	(8.5) 5	(16.1) 82	(10.5) 70	(11.9) 68	(11.1) 138	(6.9) 35	(6.5) 30	(6.7) 65	(11.2) 102	(8.8) 104	(10.2) 206
5. Play Therapy	-	(17.9) 17	(16.7) 17	(10.2) 46	(3.4) 2	(9.4) 48	(0.2) 1	(0.7) 4	(0.4) 5	-	(0.2) 1	(0.1) 1	(2.9) 47	(2.0) 24	(2.5) 71
6. Chemotherapy	-	(9.5) 9	(8.8) 9	-	-	-	(0.3) 2	(0.7) 4	(0.5) 6	(3.2) 16	(1.3) 6	(2.3) 22	(1.1) 18	(1.6) 19	(1.3) 37
7. E.C.T.	-	-	-	-	-	-	-	-	-	(0.2) 1	-	(0.1) 1	(0.1) 1	-	(0.40) 1
8. Behavior Therapy	-	(3.2) 3	(2.9) 3	(13.4) 60	(1.7) 1	(12.0) 61	(20.4) 136	(15.2) 87	(18.0) 223	(8.3) 42	(5.0) 23	(6.7) 65	(14.6) 238	(9.6) 114	(12.5) 352
9. Marital Therapy	-	(6.3) 6	(5.9) 6	-	-	-	(0.2) 1	-	(0.1) 1	(0.4) 2	(0.2) 1	(0.3) 3	(0.2) 3	(0.6) 7	(0.4) 10
10. Other	(14.3) 1	(17.9) 17	(17.6) 18	(22.5) 101	(15.3) 9	(21.7) 110	(35.4) 236	(28.5) 163	(32.2) 399	(26.0) 131	(15.7) 72	(21.1) 203	(28.8) 469	(22.0) 261	(26.0) 730
12. Assessment	(28.6) 2	(6.3) 6	(7.8) 8	(8.9) 40	(10.6) 11	(10.0) 51	(6.5) 43	(8.9) 51	(7.6) 94	(11.5) 58	(18.7) 86	(15.0) 144	(8.8) 143	(13.0) 154	(10.6) 297
13. Counselling	-	(4.2) 4	(3.9) 4	(5.6) 25	(11.9) 7	(6.3) 32	(3.3) 22	(8.4) 48	(5.7) 70	(8.7) 44	(16.6) 76	(12.5) 120	(5.6) 91	(11.4) 135	(8.0) 226
TOTAL	(100.1) 7	(100.1) 95	(99.9) 102	(99.9) 449	(100.1) 59	(99.9) 500	(100.1) 666	(100.0) 572	(100.0) 1238	(100.0) 504	(100.0) 459	(99.9) 963	(99.9) 1626	(100.0) 1105	(99.94) 2811

TABLE 20 (cont.)

(03)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	-	-	-	-	-	-	-	(20.0) 5	(20.0) 5	(25.9) 60	(29.4) 110	(28.1) 170	(25.9) 60	(28.8) 115	(27.7) 175
2. Parent Therapy	-	-	-	-	-	-	-	-	-	-	(0.3) 1	(0.2) 1	-	(0.3) 1	(0.2) 1
3. Family Therapy	-	-	-	-	-	-	-	-	-	(3.4) 8	(0.3) 1	(1.5) 9	(3.4) 8	(0.3) 1	(1.4) 9
4. Group Therapy	-	-	-	-	-	-	-	-	-	(2.6) 6	(2.1) 8	(2.3) 14	(2.6) 6	(2.0) 8	(2.2) 14
5. Play Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6. Chemotherapy	-	-	-	-	-	-	-	(20.0) 5	(20.0) 5	(15.1) 35	(5.6) 21	(9.2) 56	(15.1) 35	(6.5) 26	(9.7) 61
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Behavior Therapy	-	-	-	-	-	-	-	-	-	(3.4) 8	(0.5) 2	(1.7) 10	(3.4) 8	(0.5) 2	(1.6) 10
9. Marital Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
10. Other	-	-	-	-	-	-	-	(16.0) 4	(16.0) 4	(13.4) 31	(19.8) 74	(17.3) 105	(13.4) 31	(19.5) 78	(17.3) 109
12. Assessment	-	-	-	-	-	-	-	(40.0) 10	(40.0) 10	(27.2) 63	(21.7) 81	(23.8) 144	(27.2) 63	(22.8) 91	(24.4) 154
13. Counselling	-	-	-	-	-	-	-	(4.0) 1	(4.0) 1	(9.1) 21	(20.3) 76	(16.0) 97	(9.1) 21	(19.3) 77	(15.5) 98
TOTAL	-	-	-	-	-	-	-	(100.0) 25	(100.0) 25	(100.1) 232	(100.0) 374	(100.1) 606	(100.1) 232	(100.0) 399	(100.0) 631

TABLE 20 (cont.)

(04)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	-	-	-	(100.0) 1	-	(100.0) 1	(3.6) 1	(47.1) 8	(20.0) 9	(30.1) 107	(24.6) 52	(28.1) 159	(28.3) 109	(26.3) 60	(27.6) 169
2. Parent Therapy	-	-	-	-	-	-	-	(5.9) 1	(2.2) 1	(1.7) 6	(2.8) 6	(2.1) 12	(1.6) 6	(3.1) 7	(2.1) 13
3. Family Therapy	-	-	-	-	-	-	(25.0) 7	-	(15.6) 7	(5.9) 21	(6.2) 13	(6.0) 34	(7.3) 28	(5.7) 13	(6.7) 41
4. Group Therapy	-	-	-	-	-	-	-	-	-	(1.7) 6	(4.3) 9	(2.7) 15	(1.6) 6	(3.9) 9	(2.4) 15
5. Play Therapy	-	-	-	-	-	-	-	-	-	(0.3) 1	-	(0.2) 1	(0.3) 1	-	(0.2) 1
6. Chemotherapy	-	-	-	-	-	-	(14.3) 4	(29.4) 5	(20.0) 9	(17.2) 61	(7.1) 15	(13.4) 76	(16.9) 65	(8.8) 20	(13.9 85
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Behavior Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9. Marital Therapy	-	-	-	-	-	-	-	-	-	-	(0.5) 1	(0.2) 1	-	(0.4) 1	(0.2) 1
10. Other	-	-	-	-	-	-	(21.4) 6	(5.9) 1	(15.6) 7	(12.1) 43	(20.4) 43	(15.2) 86	(12.7) 49	(19.3) 44	(15.2) 93
12. Assessment	(100.0) 1	-	(100.0) 1	-	-	-	(32.1) 9	(5.9) 1	(22.2) 10	(13.5) 48	(17.5) 37	(15.0) 85	(15.1) 58	(16.7) 38	(15.7) 96
13. Counselling	-	-	-	-	-	-	(3.6) 1	(5.9) 1	(4.4) 2	(17.6) 62	(16.6) 35	(17.1) 97	(16.4) 63	(15.8) 36	(16.2) 99
TOTAL	(100.0) 1	-	(100.0) 1	(100.0) 1	-	(100.0) 1	(100.0) 28	(100.1) 17	(100.0) 45	(100.0) 356	(100.0) 211	(100.0) 566	(100.2) 385	(100.0) 228	(100.2) 613

TABLE 20 (cont.) IV-98

(85)

TYPE OF TREATMENT	0 - 4 Years Male	0 - 4 Years Female	0 - 4 Years Both	5 - 9 Years Male	5 - 9 Years Female	5 - 9 Years Both	10 - 14 Years Male	10 - 14 Years Female	10 - 14 Years Both	15 - 19 Years Male	15 - 19 Years Female	15 - 19 Years Both	0 - 19 Years Male	0 - 19 Years Female	0 - 19 Years Both
1. Individual Therapy	-	-	-	(5.6) 7	(3.1) 2	(4.7) 9	(21.4) 58	(16.7) 8	(20.7) 66	(24.4) 85	(40.1) 166	(32.9) 251	(20.1) 150	(33.4) 176	(25.6) 326
2. Parent Therapy	-	-	-	(10.2) 13	(14.1) 9	(11.5) 22	(12.2) 33	(12.5) 6	(12.2) 39	(1.1) 4	(1.9) 8	(1.6) 12	(6.7) 50	(4.4) 23	(5.7) 73
3. Family Therapy	-	-	-	(2.3) 3	-	(1.6) 3	(5.2) 14	(6.3) 3	(5.3) 17	(3.4) 12	(1.7) 7	(2.5) 19	(3.9) 29	(1.9) 10	(3.1) 8
4. Group Therapy	-	-	-	(2.3) 3	-	(1.6) 3				(1.4)		(0.7)	(1.1)		(0.6)
5. Play Therapy	-	-	-	-	-	-	(0.4) 1	-	(0.3) 1	(0.3) 1	-	(1.1) 1	(0.3) 2	-	(0.2) 2
6. Chemotherapy	-	-	-	(3.1) 4	(1.6) 1	(2.6) 5	(8.5) 23	-	(7.2) 23	(16.7) 58	(24.2) 100	(20.7) 158	(11.4) 85	(19.2) 101	(14.6) 186
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Behavior Therapy	-	-	-	(7.0) 9	(3.1) 2	(5.7) 11	(4.1) 11	(4.2) 2	(4.1) 13	(6.6) 23	(1.9) 8	(4.1) 31	(5.7) 43	(2.3) 12	(4.3) 55
9. Marital Therapy	-	-	-	-	-	-	(0.7) 2	-	(0.6) 2	(0.3) 1	-	(0.1) 1	(0.4) 3	-	(0.2) 3
10. Other	(100.0) 1	(100.0) 1	(100.0) 2	(33.6) 43	(42.2) 27	(36.5) 70	(23.6) 64	(35.4) 17	(25.4) 81	(15.8) 55	(6.0) 25	(10.5) 80	(21.8) 163	(13.3) 70	(18.3) 233
12. Assessment	-	-	-	(22.7) 29	(31.3) 20	(25.5) 49	(15.1) 41	(18.8) 9	(15.7) 50	(14.7) 51	(6.8) 28	(10.4) 79	(16.2) 121	(10.8) 57	(14.0) 178
13. Counselling	-	-	-	(13.3) 17	(4.7) 3	(10.4) 20	(8.9) 24	(6.3) 3	(8.5) 27	(15.2) 53	(17.4) 72	(16.4) 125	(12.6) 94	(14.8) 78	(13.5) 172
TOTAL	(100.0) 1	(100.0) 1	(100.0) 2	(100.0) 128	(100.1) 64	(100.1) 192	(100.1) 271	(100.2) 48	(100.0) 319	(99.9) 348	(100.0) 414	(100.0) 762	(100.2) 748	(100.1) 527	(100.1) 1275

TABLE 20 (cont.)

(06)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	(2.2) 1	(14.3) 1	(3.8) 2	(4.3) 13	-	(3.4) 13	(4.4) 14	(8.2) 9	(5.4) 23	(25.5) 55	(29.6) 110	(28.1) 165	(9.5) 83	(20.8) 120	(14.0) 203
2. Parent Therapy	(15.6) 7	(14.3) 1	(16.4) 8	(10.3) 31	(10.2) 9	(10.3) 40	(9.8) 31	(12.7) 14	(10.5) 45	(1.4) 3	(2.4) 9	(2.0) 12	(8.2) 72	(5.7) 33	(7.2) 105
3. Family Therapy	-	-	-	(2.3) 7	(3.4) 3	(2.6) 10	(8.5) 27	(10.0) 11	(8.9) 38	(4.6) 10	(5.1) 19	(4.9) 29	(5.0) 44	(5.7) 33	(5.3) 77
4. Group Therapy	-	-	-	-	-	-	-	-	-	(13.0) 28	(6.5) 24	(8.9) 52	(3.2) 28	(4.2) 24	(3.6) 52
5. Play Therapy	(28.9) 13	-	(25.0) 13	(17.3) 52	(34.1) 30	(21.1) 82	(17.4) 55	(16.4) 18	(17.1) 73	(0.5) 1	-	(0.2) 1	(13.8) 121	(8.3) 48	(11.6) 169
6. Chemotherapy	-	-	-	(4.3) 13	-	(3.4) 13	-	-	-	-	(1.6) 6	(1.0) 6	(1.5) 11	(1.0) 6	(1.3) 19
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Behavior Therapy	(2.2) 1	-	(1.9) 1	(1.0) 3	-	(0.8) 3	(2.2) 7	-	(1.6) 7	(3.7) 8	(4.9) 18	(4.4) 26	(2.2) 19	(3.1) 18	(2.5) 37
9. Marital Therapy	-	-	-	(0.3) 1	-	(0.3) 1	(0.6) 2	-	(0.5) 2	-	(0.8) 3	(0.5) 3	(0.3) 3	(0.5) 3	(0.4) 6
10. Other	(2.2) 1	-	(1.9) 1	(1.3) 4	(2.3) 2	(1.5) 6	(4.4) 14	(7.3) 8	(5.2) 22	(12.5) 27	(5.9) 22	(8.3) 49	(5.2) 46	(5.6) 32	(5.4) 78
12. Assessment	(35.6) 16	(71.4) 5	(40.4) 21	(36.7) 110	(33.0) 29	(35.8) 139	(28.1) 89	(30.0) 33	(28.6) 122	(7.9) 17	(21.6) 80	(16.5) 97	(26.4) 232	(25.5) 147	(26.1) 379
13. Counselling	(13.3) 6	-	(11.5) 6	(22.0) 66	(17.0) 15	(20.9) 81	(24.6) 78	(15.5) 17	(22.2) 95	(31.0) 67	(21.6) 80	(25.0) 147	(24.7) 217	(19.4) 112	(22.6) 329
TOTAL	(100.0) 45	(100.0) 7	(99.9) 52	(99.8) 300	(100.0) 88	(100.1) 388	(100.0) 317	(100.1) 110	(100.0) 427	(100.1) 216	(100.0) 371	(99.8) 587	(100.0) 878	(99.8) 576	(100.0) 1454

TABLE 20 (cont.)

(07)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	-	-	-	(3.0) 14	(2.6) 1	(2.9) 16	(19.8) 143	(27.6) 95	(22.3) 238	(16.9) 14	(22.6) 67	(21.3) 81	(13.3) 171	(23.9) 163	(17.0) 335
2. Parent Therapy	(25.0) 2	-	(20.0) 2	(25.5) 121	(10.5) 4	(24.4) 125	(7.3) 53	(5.5) 19	(6.7) 72	(4.8) 4	(7.7) 23	(7.1) 27	(14.0) 180	(6.7) 46	(11.5) 226
3. Family Therapy	-	-	-	(0.4) 2	-	(0.4) 2	(4.4) 32	(5.2) 18	(4.7) 50	(2.4) 2	(2.7) 8	(2.6) 10	(2.8) 36	(3.8) 26	(3.1) 62
4. Group Therapy	-	-	-	-	-	-	(9.6) 69	(12.2) 42	(10.4) 111	(4.8) 4	(26.9) 80	(22.1) 84	(5.7) 73	(17.9) 122	(9.9) 195
5. Play Therapy	-	-	-	(0.2) 1	-	(0.2) 1	(14.0) 101	(16.2) 56	(14.7) 157	-	-	-	(7.9) 102	(8.2) 56	(8.0) 158
6. Chemotherapy	-	-	-	(9.1) 43	-	(8.4) 43	(4.2) 30	(4.1) 14	(4.1) 44	(4.8) 4	(5.4) 16	(5.3) 20	(6.0) 77	(4.4) 30	(5.4) 107
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	(0.3) 1	(0.3) 1	-	(0.1) 1	(0.1) 1
8. Behavior Therapy	-	-	-	(13.5) 64	(21.1) 8	(14.1) 72	(8.0) 58	(6.7) 23	(7.6) 81	(1.2) 1	(1.7) 5	(1.6) 6	(9.6) 123	(5.3) 36	(8.1) 159
9. Marital Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
10. Other	(62.5) 5	(50.0) 1	(60.0) 6	(30.8) 146	(34.2) 13	(31.1) 159	(13.7) 99	(3.8) 13	(10.5) 112	(32.5) 27	(14.1) 42	(18.2) 69	277	(10.1) 69	(17.6) 346
12. Assessment	(12.5) 1	(50.0) 1	(20.0) 2	(11.0) 52	(23.7) 9	(11.9) 61	(6.8) 49	(6.7) 23	(6.7) 72	(16.9) 14	(8.8) 26	(10.5) 40	(9.0) 116	(8.7) 59	(8.9) 175
13. Counselling	-	-	-	(6.5) 31	(7.9) 3	(6.6) 34	(12.2) 88	(12.2) 42	(12.2) 130	(15.7) 13	(9.8) 29	(11.1) 42	(10.3) 132	(10.9) 74	(10.5) 206
TOTAL	(100.0) 8	(100.0) 2	(100.0) 10	(100.2) 474	(100.0) 38	(100.0) 512	(100.0) 722	(100.1) 345	(99.9) 1067	(100.0) 83	(100.0) 297	(100.1) 380	(100.1) 1287	(100.0) 682	(100.1) 1969

TABLE 20 (cont.)

(OA)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	-	-	-	(7.4) 2	-	(4.5) 2	(19.2) 28	(15.9) 11	(18.1) 39	(29.4) 60	(26.1) 52	(27.8) 112	(23.4) 90	(22.0) 63	(22.8) 153
2. Parent Therapy	-	-	-	-	-	-	(4.1) 6	(2.9) 2	(3.7) 8	-	(2.0) 4	(1.0) 4	(1.6) 6	(2.1) 6	(1.8) 12
3. Family Therapy	-	(50.0) 1	(11.1) 1	(14.8) 4	-	(9.1) 4	(8.9) 13	(14.5) 10	(10.7) 23	(10.8) 22	(15.1) 30	(12.9) 52	(10.2) 39	(14.3) 41	(11.9) 80
4. Group Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Play Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6. Chemotherapy	-	-	-	-	-	-	(3.4) 5	(1.4) 1	(2.8) 6	(3.9) 8	(2.5) 5	(3.2) 13	(3.4) 13	(2.1) 6	(2.8) 19
7. E.C.T.	-	-	-	-	-	-	(0.7) 1	-	(0.5) 1	-	-	-	(0.3) 1	-	(0.1) 1
8. Behavior Therapy	(71.4) 5	-	(55.6) 5	(3.7) 1	-	(2.3) 1	(7.5) 11	(10.1) 7	(8.4) 18	-	(0.5) 1	(0.2) 1	(4.4) 17	(2.8) 8	(3.7) 25
9. Marital Therapy	-	-	-	(7.4) 2	-	(4.5) 2	(2.1) 3	(4.3) 3	(2.8) 6	-	(0.5) 1	(0.2) 1	(1.3) 5	(1.4) 4	(1.3) 9
10. Other	(14.3) 1	-	(11.1) 1	(7.4) 2	-	(4.5) 2	(5.5) 8	(4.3) 3	(5.1) 11	(11.3) 23	(9.0) 18	(10.2) 41	(8.9) 34	(7.3) 21	(8.2) 55
12. Assessment	(14.3) 1	-	(11.1) 1	(22.2) 6	(47.1) 8	(31.8) 14	(15.1) 22	(17.4) 12	(15.8) 34	(10.3) 21	(12.6) 25	(11.4) 46	(13.0) 50	(15.7) 45	(14.2) 95
13. Counselling	-	(50.0) 1	(11.1) 1	(37.0) 10	(52.9) 9	(43.2) 19	(33.6) 49	(29.0) 20	(32.1) 69	(34.3) 70	(31.7) 63	(33.0) 133	(33.6) 129	(32.4) 93	(33.1) 222
TOTAL	(100.0) 7	(100.0) 2	(100.0) 9	(99.9) 27	(100.0) 17	(99.9) 44	(100.1) 146	(99.8) 69	(100.0) 215	(100.0) 204	(100.0) 199	(99.9) 403	(100.1) 384	(100.1) 287	(99.9) 671

TABLE 20 (cont.)

(09)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	-	-	-	(10.3) 13	(8.8) 3	(10.0) 16	(25.8) 65	(36.1) 57	(29.8) 122	(50.2) 131	(51.9) 135	(51.1) 266	(32.0) 209	(42.2) 195	(36.2) 404
2. Parent Therapy	-	-	-	(6.3) 8	-	(5.0) 8	(7.1) 18	(5.7) 9	(6.6) 27	(7.7) 20	(11.2) 29	(9.4) 49	(7.0) 46	(8.2) 38	(7.5) 84
3. Family Therapy	-	-	-	(4.8) 6	-	(3.8) 6	(5.6) 14	(12.7) 20	(8.3) 34	(1.1) 3	(1.2) 3	(1.2) 6	(3.5) 23	(5.0) 23	(4.1) 46
4. Group Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Play Therapy	-	-	-	-	-	-	(0.4) 1	-	(0.2) 1	-	-	-	(0.2) 1	-	(0.1) 1
6. Chemotherapy	-	-	-	(0.8) 1	(5.9) 2	(1.9) 3	(1.6) 4	(1.9) 3	(1.7) 7	(13.8) 36	(8.1) 21	(10.9) 57	(6.3) 41	(5.6) 26	(6.0) 67
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-
8. Behavior Therapy	-	-	-	-	-	-	(1.2) 3	-	(0.7) 3	(1.1) 3	-	(0.6) 3	(0.9) 6	-	(0.5) 6
9. Marital Therapy	-	-	-	(1.6) 2	-	(1.3) 2	-	-	-	-	-	-	(0.3) 2	-	(0.2) 2
10. Other	(7.1) 1	(10.0) 1	(8.3) 2	(16.7) 21	(35.3) 12	(20.6) 33	(18.3) 46	(15.8) 25	(17.3) 71	(6.9) 18	(8.5) 22	(7.7) 40	(13.2) 86	(13.0) 60	(13.1) 146
12. Assessment	(7.1) 1	(10.0) 1	(8.3) 2	(19.8) 25	(17.6) 6	(19.4) 31	(12.3) 31	(13.9) 22	(12.9) 53	(13.8) 36	(17.3) 45	(15.5) 81	(14.2) 93	(16.0) 74	(15.0) 167
13. Counselling	(85.7) 12	(80.0) 8	(83.3) 20	(39.7) 50	(32.4) 11	(38.1) 61	(27.8) 70	(13.9) 22	(22.4) 92	(5.4) 14	(1.9) 5	(3.6) 19	(22.4) 146	(10.0) 46	(17.2) 192
TOTAL	(99.9) 14	(100.0) 10	(99.9) 24	(100.0) 126	(100.0) 34	(100.1) 160	(100.1) 252	(100.1) 158	(99.9) 410	(100.0) 261	(100.1) 260	(100.0) 521	(100.0) 653	(100.0) 462	(99.9) 1115

TABLE 20 (cont.)

(10)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	-	(20.0) 1	(11.1) 1	(12.5) 5	(8.7) 2	(11.1) 7	(19.6) 27	(31.3) 35	(24.8) 62	(48.1) 88	(51.5) 122	(50.0) 210	(32.9) 120	(42.4) 160	(37.7) 280
2. Parent Therapy	-	(60.0) 3	(33.3) 3	(17.5) 7	(30.4) 7	(22.2) 14	(8.7) 12	(4.5) 5	(6.8) 17	(0.5) 1	(0.4) 1	(0.5) 2	(5.5) 20	(4.2) 16	(4.9) 36
3. Family Therapy	(25.0) 1	-	(11.1) 1	(22.5) 9	(17.4) 4	(20.6) 13	(15.9) 22	(26.8) 30	(20.8) 52	(7.1) 13	(16.5) 39	(12.4) 52	(12.3) 45	(19.4) 73	(15.9) 118
4. Group Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Play Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6. Chemotherapy	-	-	-	(5.0) 2	-	(3.2) 2	(2.2) 3	(0.9) 1	(1.6) 4	(15.3) 28	(6.3) 15	(10.2) 43	(9.0) 33	(4.2) 16	(6.6) 49
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Behavior Therapy	-	-	-	-	-	-	(0.7) 1	-	(0.4) 1	(0.5) 1	-	(0.2) 1	(0.5) 2	-	(0.3) 2
9. Marital Therapy	-	-	-	-	-	-	(0.7) 1	-	(0.4) 1	-	(1.3) 3	(0.7) 3	(0.3) 1	(0.8) 3	(0.5) 4
10. Other	-	-	-	(17.5) 7	(34.8) 8	(23.8) 15	(16.7) 23	(9.8) 11	(13.6) 34	(2.7) 5	(5.1) 12	(4.0) 17	(9.6) 35	(8.2) 31	(8.9) 66
12. Assessment	(75.0) 3	(20.0) 1	(44.4) 4	(12.5) 5	(4.3) 1	(9.5) 6	(6.5) 9	(12.5) 14	(9.2) 23	(7.1) 13	(8.4) 20	(7.9) 33	(8.2) 30	(9.5) 36	(8.9) 66
13. Counselling	-	-	-	(12.5) 5	(4.3) 1	(9.5) 6	(29.0) 40	(14.3) 16	(22.4) 56	(18.6) 34	(10.5) 25	(14.0) 59	(21.6) 79	(11.1) 42	(16.3) 121
TOTAL	(100.0) 4	(100.0) 5	(99.9) 9	(100.0) 40	(99.9) 23	(99.9) 63	(100.0) 138	(100.1) 112	(100.0) 250	(99.9) 183	(100.0) 237	(99.9) 420	(99.9) 365	(99.8) 377	(100.0) 742

TABLE 20 (cont.)

(ii)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	(5.3) 1	-	(5.3) 1	(4.6) 13	(7.9) 10	(5.6) 23	(17.0) 101	(11.8) 9	(16.4) 110	(15.0) 26	(37.1) 104	(28.7) 130	(13.2) 141	(25.5) 123	(17.0) 264
2. Parent Therapy	(26.3) 5	-	(26.3) 5	(16.5) 47	(21.3) 27	(18.0) 74	(9.9) 59	(3.9) 3	(9.3) 62	(4.0) 7	(5.0) 14	(4.6) 21	(11.0) 118	(9.1) 44	(10.4) 162
3. Family Therapy	-	-	-	(1.8) 5	(1.6) 2	(1.7) 7	(1.3) 8	-	(1.2) 8	(0.6) 1	(1.1) 3	(0.9) 4	(1.3) 14	(1.0) 5	(1.2) 19
4. Group Therapy	-	-	-	-	-	-	(13.7) 81	-	(12.1) 81	(15.0) 26	-	(5.7) 26	(10.0) 107	-	(6.9) 107
5. Play Therapy	-	-	-	(0.4) 1	-	(0.2) 1	-	-	-	-	-	-	(0.1) 1	-	(0.1) 1
6. Chemotherapy	-	-	-	-	-	-	-	-	-	(0.6) 1	-	(0.2) 1	(0.1) 1	-	(0.1) 1
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Behavior Therapy	-	-	-	(8.1) 23	-	(5.6) 23	(5.9) 35	(5.3) 4	(5.8) 39	-	-	-	(5.4) 58	(0.8) 4	(4.0) 62
9. Marital Therapy	-	-	-	(0.4) 1	-	(0.2) 1	-	-	-	-	-	-	(0.1) 1	-	(0.1) 1
10. Other	-	-	-	(2.1) 6	(3.1) 4	(2.4) 10	(5.2) 31	(10.5) 8	(5.8) 39	(9.8) 17	(6.8) 19	(7.9) 36	(5.1) 54	(6.4) 31	(5.5) 85
12. Assessment	(26.3) 5	-	(26.3) 5	(22.2) 63	(16.5) 21	(20.4) 84	(15.5) 92	(21.1) 16	(16.1) 108	(20.2) 35	(8.9) 25	(13.2) 60	(18.2) 195	(12.8) 62	(16.6) 257
13. Counselling	(42.1) 8	-	(42.1) 8	(44.0) 125	(49.6) 63	(45.7) 188	(31.4) 186	(47.4) 36	(33.2) 222	(34.7) 60	(41.1) 115	(38.6) 175	(35.5) 379	(44.3) 214	(38.2) 593
TOTAL	(100.0) 19	-	(100.0) 19	(100.1) 284	(100.5) 127	(99.8) 411	(99.9) 593	(100.0) 76	(99.9) 669	(99.9) 173	(100.0) 280	(99.8) 453	(100.0) 1069	(99.9) 483	(100.1) 1552

TABLE 20 (cont.)

(12)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	(7.1) 2	(4.2) 1	(5.8) 3	(10.7) 32	(16.0) 15	(11.9) 47	(18.0) 46	(17.6) 40	(17.8) 86	(35.4) 179	(53.8) 243	(44.1) 422	(23.8) 259	(37.5) 299	(29.6) 558
2. Parent Therapy	(25.0) 7	(37.5) 9	(30.8) 16	(15.0) 45	(24.5) 23	(17.3) 68	(8.2) 21	(14.0) 32	(11.0) 53	(1.8) 9	(6.0) 27	(3.8) 36	(7.5) 82	(11.4) 91	(9.2) 173
3. Family Therapy	(3.6) 1	(4.2) 1	(3.8) 2	(4.0) 12	(1.1) 1	(3.3) 13	((6.6) 17	(14.5) 33	(10.3) 50	(4.3) 22	(3.1) 14	(3.8) 36	(4.8) 52	(6.1) 49	(5.3) 101
4. Group Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Play Therapy	-	-	-	(2.3) 7	(1.1) 1	(2.0) 8	-	(0.9) 2	(0.4) 2	-	-	-	(0.6) 7	(0.4) 3	(0.5) 10
6. Chemotherapy	(3.6) 1	-	(1.9) 1	(8.7) 26	(2.1) 2	(7.1) 28	(7.8) 20	(6.6) 15	(7.2) 35	(9.9) 50	(6.2) 28	(8.1) 78	(8.9) 97	(5.6) 45	(7.5) 142
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Behavior Therapy	-	-	-	(1.7) 5	(3.2) 3	(2.0) 8	(3.6) 9	(3.1) 7	(3.3) 16	-	(2.9) 13	(1.4) 13	(1.3) 14	(2.9) 23	(2.0) 37
9. Marital Therapy	-	-	-	-	-	-	(0.4) 1	-	(0.2) 1	-	-	-	(0.1) 1	-	(0.1) 1
10. Other	(17.9) 5	(33.3) 8	(25.0) 13	(22.3) 67	(19.1) 18	(21.6) 85	(17.2) 44	(17.5) 40	(17.4) 84	(15.2) 77	(11.5) 52	(13.5) 129	(17.7) 193	(14.8) 118	(16.5) 311
12. Assessment	(3.6) 1	(4.2) 1	(3.8) 2	(6.0) 18	(4.3) 4	(5.6) 22	(5.9) 15	(3.1) 7	(4.5) 22	(2.6) 13	(2.4) 11	(2.5) 24	(4.3) 47	(2.9) 23	(3.7) 70
13. Counselling	(39.3) 11	(16.7) 4	(28.8) 15	(29.3) 88	(28.7) 27	(29.2) 115	(32.4) 83	(22.8) 52	(27.9) 135	(30.8) 156	(14.2) 64	(23.0) 220	(31.0) 338	(18.4) 147	(25.7) 485
TOTAL	(100.1) 28	(100.1) 24	(99.9) 52	(100.0) 300	(100.1) 94	(100.0) 394	(100.0) 256	(100.0) 228	(100.0) 484	(100.0) 506	(100.1) 452	(100.2) 958	(100.0) 1090	(100.0) 798	(100.1) 1888

TABLE 20 (cont.)

(13)

TYPE OF TREATMENT	0 - 4 Years			5 - 9 Years			10 - 14 Years			15 - 19 Years			0 - 19 Years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Individual Therapy	(8.6) 24	(2.4) 3	(6.6) 27	(10.7) 124	(11.5) 58	(11.0) 182	(18.6) 262	(24.0) 210	(20.7) 472	(28.4) 200	(30.5) 198	(29.4) 398	(17.2) 610	(21.8) 469	(18.9) 1079
2. Parent Therapy	(10.7) 30	(17.3) 22	(12.8) 52	(15.4) 178	(15.5) 78	(15.4) 256	(17.4) 245	(11.9) 104	(15.3) 349	(12.2) 86	(10.8) 70	(11.5) 156	(15.2) 539	(12.7) 274	(14.3) 813
3. Family Therapy	(32.5) 91	(27.6) 35	(31.0) 126	(33.1) 383	(37.4) 188	(34.4) 571	(29.7) 418	(34.4) 301	(31.5) 719	(27.0) 190	(26.2) 170	(26.6) 360	(30.5) 1082	(32.2) 694	(31.1) 1776
4. Group Therapy	-	-	-	-	-	-	-	-	-	(0.3) 2	(0.5) 3	(0.4) 5	(0.1) 2	(0.1) 3	(0.1) 5
5. Play Therapy	(1.1) 3	-	(0.7) 3	(9.3) 108	(2.8) 14	(7.3) 122	(1.7) 24	(1.0) 9	(1.4) 33	-	(0.3) 2	(0.1) 2	(3.8) 135	(1.2) 25	(2.8) 160
6. Chemotherapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Behavior Therapy	(11.4) 32	(4.7) 6	(9.3) 38	(3.8) 44	(2.4) 12	(3.4) 56	(2.6) 36	(1.4) 12	(2.1) 48	(1.0) 7	(0.9) 6	(1.0) 13	(3.4) 119	(1.7) 36	(2.7) 155
9. Marital Therapy	(3.6) 10	(2.4) 3	(3.2) 13	(1.8) 21	(4.8) 24	(2.7) 45	(1.0) 14	(2.1) 18	(1.4) 32	(1.4) 10	(3.9) 25	(2.6) 35	(1.5) 55	(3.2) 70	(2.2) 125
10. Other	(9.6) 27	(7.9) 10	(9.1) 37	(6.4) 74	(5.6) 28	(6.1) 102	(9.2) 130	(5.8) 51	(7.9) 181	(8.9) 63	(8.8) 57	(8.9) 120	(8.3) 294	(6.8) 146	(7.7) 440
12. Assessment	(14.6) 41	(32.3) 41	(20.1) 82	(13.3) 154	(14.9) 75	(13.8) 229	(15.2) 214	(13.5) 118	(14.5) 332	(12.9) 91	(12.9) 84	(12.9) 175	(14.1) 500	(14.8) 318	(14.3) 818
13. Counselling	(7.9) 22	(5.5) 7	(7.1) 29	(6.1) 71	(5.2) 26	(5.8) 97	(4.6) 65	(6.1) 53	(5.2) 118	(7.9) 56	(5.2) 34	(6.6) 90	(6.0) 214	(5.6) 120	(5.9) 334
TOTAL	(100.0) 280	(100.1) 127	(99.9) 407	(99.9) 1157	(100.1) 503	(99.9) 1660	(100.0) 1408	(100.2) 876	(100.0) 2284	(100.0) 705	(100.0) 649	(100.0) 1354	(100.1) 3550	(100.1) 2155	(100.0) 5705

TABLE 20 (cont.)
, ROW TOTALS

TYPE OF TREATMENT	0 - 19 Years		
	Male	Female	Both
	(20.4)	(29.8)	(24.3)
1. Individual Therapy	2601	2702	5303
	(10.2)	(7.7)	(9.2)
2. Parent Therapy	1297	703	2000
	(12.6)	(12.6)	(12.6)
3. Family Therapy	1607	114	2740
	(3.2)	(3.0)	(3.1)
4. Group Therapy	405	272	677
	(3.4)	(1.9)	(2.8)
5. Play Therapy	430	173	603
	(4.1)	(3.6)	(3.8)
6. Chemotherapy	517	322	839
	(0.0)	(0.0)	(0.0)
7. E.C.T.	4	1	5
	(5.2)	(3.3)	(4.4)
8. Behavior Therapy	666	292	958
	(0.6)	(1.0)	(0.8)
9. Marital Therapy	78	93	171
	(11.3)	(10.7)	(11.1)
10. Other	1443	975	2418
	(13.8)	(13.0)	(13.5)
12. Assessment	1758	1178	2936
	(15.3)	(13.5)	(14.5)
13. Counselling	1949	1226	3175
	(100.1)	(100.1)	(100.1)
TOTAL	12755	9078	21833

1. Figures in parentheses are percentages of column totals.

Table 21 discusses the percentage of ages 0-19 outpatients who have been treated previously. These data were calculated for 1980 and show, not surprisingly, that a substantial portion of young people seen as outpatients had received previous treatment (either in the same or in a different facility). The range is from 26.9 to 92.4 percent. Unfortunately, it was not possible to distinguish between patients who had been previously treated once from patients who had been previously treated a number of times. Moreover, at least some of the variability from facility to facility may be due to differences in their relative readiness to close a case for statistical purposes and then reopen subsequently. The fact that the Department of Health's computer system automatically lapses a case 90 days after the indicated "next appointment" may inflate the number of previously treated patients/clients.

Why are young people referred to Nova Scotia mental health facilities? Table 22 attempts to answer this question. Unfortunately, reason for referral is an "optional" item and only six facilities consistently make use of it for more than 50 percent of all cases. It is impossible to state whether these six facilities are or are not representative. Table 22's results may only be taken, therefore, as suggestive.

These results do bear out the remark made by many mental health staff that young people tend to be referred when their behaviour becomes in some way a nuisance to others. For the 0-14 age group, "socially disruptive behaviour" was the presenting problem for 34 percent of referrals for the six facilities included in the table, in 1981. The figure drops to 30 percent for the 15-19 age group, though mental health staff had generally expected this percentage to increase rather than decrease for the older age group. Males are somewhat more likely than females to be referred for "socially disruptive behaviour", this problem being indicated for 36 percent of all males referred but 28 percent of the females. On the other hand, females are more likely than males to be referred for "self-oriented disturbance". This last difference is especially marked for the 15-19 year old group, where only 23 percent of females were referred for socially disruptive behaviour while self-

TABLE 21

PERCENTAGE OF OUTPATIENTS PREVIOUSLY TREATED, BY FACILITY AND AGE GROUP, 1980.

FACILITY		AGE GROUP				
		0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
(01)	# of Registrants[1]	55	141	214	76	486
	% Previously Treated	20.0	31.9	43.5	39.5	36.8
(02)	# of Registrants	8	28	35	53	124
	% Previously Treated	37.5	17.9	34.3	11.3	21.0
(03)	# of Registrants	--	--	--	108	108
	% Previously Treated	--	--	--	43.5	43.5
(04)	# of Registrants	--	16	66	98	180
	% Previously Treated	--	81.3	83.3	61.2	71.1
(05)	# of Registrants	9	43	52	93	197
	% Previously Treated	11.1	32.6	23.1	47.3	36.0
(06)	# of Registrants	6	20	26	69	121
	% Previously Treated	16.7	40.0	30.8	44.9	39.7
(07)	# of Registrants	4	36	25	45	110
	% Previously Treated	50.0	25.0	20.0	42.2	31.8
(08)	# of Registrants	1	6	23	22	52
	% Previously Treated	100.0	33.3	17.4	31.8	25.9
(09)	# of Registrants	6	63	70	71	210
	% Previously Treated	0.0	23.8	31.4	38.0	30.5
(10)	# of Registrants	10	35	50	74	169
	% Previously Treated	20.0	57.1	56.0	56.8	54.4
(11)	# of Registrants	15	60	66	56	197
	% Previously Treated	93.3	86.7	95.5	94.6	92.4
(12)	# of Registrants	11	47	63	96	217
	% Previously Treated	18.2	31.9	44.4	56.3	45.6
(13)	# of Registrants	112	257	255	97	741
	% Previously Treated	31.3	38.5	50.9	61.9	44.3
ROW TOTALS						
	# of Registrants	237	762	955	364	2918
	% Previously Treated	30.4	39.5	48.7	50.4	45.4

Table 22. Reason for Referral, by Age Group and Sex, for Six Outpatient Mental Health Facilities, 1981.

	04														
	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
REASON FOR REFERRAL	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Social Disruptive Behavior	(100.0) 1	-	(100.0) 1	(75.0) 6	(50.0) 2	(66.7) 8	(80.0) 24	(83.3) 15	(81.3) 39	(49.3) 34	(41.5) 22	(45.9) 56	(60.2) 65	(52.0) 39	(56.8) 104
2. Disoriented Bizarre Behavior	-	-	-	-	(25.0) 1	(8.3) 1	(3.3) 1	-	(2.1) 1	(7.2) 5	(3.8) 2	(5.7) 7	(5.6) 6	(4.0) 3	(4.9) 9
3. Self-Oriented Disturbance	-	-	-	-	-	-	(3.3) 1	(11.1) 2	(6.3) 3	(27.5) 19	(35.8) 19	(31.1) 38	(18.5) 20	(28.0) 21	(22.4) 41
4. Family/Marital Maladjustment	-	-	-	-	-	-	(6.7) 2	-	(4.2) 2	(5.8) 4	(9.4) 5	(7.4) 9	(5.6) 6	(6.7) 5	(6.0) 11
5. Developmental Disorder	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6. Other	-	-	-	-	-	-	(6.7) 2	(5.6) 1	(6.3) 3	(2.9) 2	(1.9) 1	(2.5) 3	(3.7) 4	(2.7) 2	(3.3) 6
8. Not Given	-	-	-	(25.0) 2	(25.0) 1	(25.0) 3	-	-	-	(7.2) 5	(7.5) 4	(7.4) 9	(6.5) 7	(6.7) 5	(6.6) 12
TOTAL	(100.0) 1	-	(100.0) 1	(100.0) 8	(100.0) 4	(100.0) 12	(100.0) 30	(100.0) 18	(100.2) 48	(99.9) 69	(99.9) 53	(100.0) 122	(100.1) 108	(100.1) 75	(100.0) 183

Table 22 (cont.)

	07														
	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
REASON FOR REFERRAL	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Social Disruptive Behavior	-	-	-	(57.9) 11	(66.7) 4	(60.0) 15	(21.4) 6	(12.5) 2	(18.2) 8	(16.7) 2	(24.0) 6	(21.6) 8	(31.1) 19	(25.0) 12	(28.4) 31
2. Disoriented Bizarre Behavior	-	-	-	-	-	-	-	-	-	(8.3) 1	-	(2.7) 1	(1.6) 1	-	(0.9) 1
3. Self-Oriented Disturbance	-	-	-	(10.5) 2	(16.7) 1	(12.0) 3	(42.9) 12	(56.3) 9	(47.7) 21	(75.0) 9	(60.0) 15	(64.9) 24	(37.7) 23	(52.1) 25	(44.0) 48
4. Family/Marital Maladjustment	-	-	-	(5.3) 1	-	(4.0) 1	(17.9) 5	(6.3) 1	(13.6) 6	-	(16.0) 4	(10.8) 4	(9.8) 6	(10.4) 5	(10.1) 11
5. Developmental Disorder	(50.0) 1	-	(33.3) 1	-	-	-	(3.6) 1	-	(2.3) 1	-	-	-	(3.3) 2	-	(1.8) 2
6. Other	-	-	-	(10.5) 2	(16.7) 1	(12.0) 3	(10.7) 3	(12.5) 2	(11.4) 5	-	-	-	(8.2) 5	(6.3) 3	(7.3) 8
0. Not Given	(50.0) 1	(100.0) 1	(66.7) 2	(15.8) 3	-	(12.0) 3	(3.6) 1	(12.5) 2	(6.8) 3	-	-	-	(8.2) 5	(6.3) 3	(7.3) 8
TOTAL	(100.0) 2	(100.0) 1	(100.0) 3	(100.0) 19	(100.1) 6	(100.0) 25	(100.1) 28	(100.1) 16	(100.0) 44	(100.0) 12	(100.0) 25	(100.0) 37	(99.9) 61	(100.1) 48	(99.8) 109

Table 22 (cont.)

	OD														
	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
REASON FOR REFERRAL	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Social Disruptive Behavior	(33.3) 1	-	(20.0) 1	(42.9) 3	-	(30.0) 3	(32.4) 11	(28.6) 4	(31.3) 15	(25.8) 8	(13.8) 4	(20.0) 12	(30.7) 23	(16.7) 8	(25.2) 31
2. Disoriented Bizarre Behavior	(33.3) 1	-	(20.0) 1	-	-	-	(2.9) 1	-	(2.1) 1	-	-	-	(2.7) 2	-	(1.6) 2
3. Self-Oriented Disturbance	-	(50.0) 1	(20.0) 1	-	-	-	(23.5) 8	(14.3) 2	(20.0) 10	(25.8) 8	(34.5) 10	(30.0) 18	(21.3) 16	(27.1) 13	(23.6) 29
4. Family/Marital Maladjustment	-	-	-	-	(33.3) 1	(10.0) 1	(14.7) 5	(21.4) 3	(16.7) 8	(6.5) 2	(31.0) 9	(18.3) 11	(9.3) 7	(27.1) 13	(16.3) 20
5. Developmental Disorder	(33.3) 1	-	(20.0) 1	-	-	-	-	-	-	-	-	-	(1.3) 1	-	(0.8) 1
6. Other	-	(50.0) 1	(20.0) 1	(14.3) 1	-	(10.0) 1	(5.9) 2	(7.1) 1	(6.3) 3	(9.7) 3	(3.4) 1	(6.7) 4	(8.0) 6	(6.3) 3	(7.3) 9
N. Not Given	-	-	-	(42.9) 3	(66.7) 2	(50.0) 5	(20.6) 7	(28.6) 4	(22.9) 11	(32.2) 10	(17.2) 5	(25.0) 15	(26.7) 20	(22.9) 11	(25.2) 31
TOTAL	(99.9) 3	(100.0) 2	(100.0) 5	(100.0) 7	(100.1) 3	(100.0) 10	(100.0) 34	(100.0) 14	(100.1) 48	(100.1) 31	(99.9) 29	(100.0) 60	(100.0) 75	(100.1) 48	(100.0) 123

TABLE 22 (cont.)

	09														
	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
REASON FOR REFERRAL	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Social Disruptive Behavior	(57.1) 4	(50.0) 6	(52.6) 10	(15.2) 7	(50.0) 8	(24.2) 15	(29.8) 14	(12.5) 3	(23.9) 17	(34.4) 11	(5.3) 2	(18.6) 13	(27.3) 36	(21.1) 19	(24.8) 55
2. Disoriented Bizarre Behavior	-	-	-	-	-	-	-	-	-	(9.4) 3	-	(4.3) 3	(2.3) 3	-	(1.4) 3
3. Self-Oriented Disturbance	-	(8.3) 1	(5.3) 1	(15.2) 7	(12.5) 2	(14.5) 9	(17.0) 8	(33.3) 8	(22.5) 16	(34.4) 11	(76.3) 29	(57.1) 40	(19.7) 26	(44.4) 40	(29.7) 66
4. Family/Marital Maladjustment	(14.3) 1	-	(5.3) 1	(4.3) 2	-	(3.2) 2	(4.3) 2	(4.2) 1	(4.2) 3	(3.1) 1	(13.2) 5	(8.6) 6	(4.5) 6	(6.7) 6	(5.4) 12
5. Developmental Disorder	-	(16.7) 2	(10.5) 2	-	(6.3) 1	(1.6) 1	-	-	-	-	-	-	-	(3.3) 3	(1.4) 3
6. Other	(14.3) 1	-	(5.3) 1	(32.6) 15	(6.3) 1	(25.8) 16	(31.9) 15	(25.0) 6	(29.6) 21	(6.3) 2	-	(2.9) 2	(25.0) 33	(7.8) 7	(18.0) 40
8. Not Given	(14.3) 1	(25.0) 3	(21.1) 4	(32.6) 15	(25.0) 4	(30.6) 19	(17.0) 8	(25.0) 6	(19.7) 14	(12.5) 4	(5.3) 2	(8.6) 6	(21.2) 28	(16.7) 15	(19.4) 43
TOTAL	(100.0) 7	(100.0) 12	(100.1) 19	(99.9) 46	(100.1) 16	(99.9) 62	(100.0) 47	(100.0) 24	((99.9) 71	(100.1) 32	(100.1) 38	(100.1) 70	(100.0) 132	(100.0) 90	(100.0) 222

TABLE 22 (cont.)

	II														
	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
REASON FOR REFERRAL	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Social Disruptive Behavior	(55.6) 5	(50.0) 2	(53.8) 7	(24.4) 10	(16.7) 2	(22.6) 12	(35.4) 17	(7.1) 1	(29.0) 18	(39.3) 11	(19.0) 4	(30.6) 15	(34.1) 43	(17.6) 9	(29.4) 52
2. Disoriented Bizarre Behavior	-	-	-	-	-	-	-	-	-	(3.6) 1	-	(2.0) 1	(0.8) 1	-	(0.6) 1
3. Self-Oriented Disturbance	(11.1) 1	-	(7.7) 1	(22.0) 9	(8.3) 1	(18.9) 10	(25.0) 12	(21.4) 3	(24.2) 15	(28.6) 8	(57.1) 12	(40.8) 20	(23.8) 30	(31.4) 16	(26.0) 46
4. Family/Marital Maladjustment	-	-	-	(9.8) 4	(8.3) 1	(9.4) 5	(4.2) 2	(7.1) 1	(4.8) 3	(7.1) 2	(9.5) 2	(8.2) 4	(6.3) 8	(7.8) 4	(6.8) 12
5. Developmental Disorder	(33.3) 3	(25.0) 1	(30.8) 4	(36.6) 15	(58.3) 7	(41.5) 22	(22.9) 11	(42.9) 6	(27.4) 17	(10.7) 3	(4.8) 1	(8.2) 4	(25.4) 32	(29.4) 15	(26.6) 47
6. Other	-	-	-	-	-	-	-	(7.1) 1	(1.6) 1	(3.6) 1	(4.8) 1	(4.1) 2	(0.8) 1	(3.9) 2	(1.7) 3
0. Not Given	-	(25.0) 1	(7.7) 1	(7.3) 3	(8.3) 1	(7.5) 4	(12.5) 6	(14.3) 2	(12.9) 8	(7.1) 2	(4.8) 1	(6.1) 3	(8.7) 11	(9.8) 5	(9.0) 16
TOTAL	(100.0) 9	(100.0) 4	(100.0) 13	(100.1) 41	(99.9) 12	(99.9) 53	(100.0) 48	(99.9) 14	(99.9) 62	(100.0) 28	(100.0) 21	(100.0) 49	(100.1) 126	(99.9) 51	(100.1) 177

TABLE 22 (cont.)

	13														
	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
REASON FOR REFERRAL	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Social Disruptive Behavior	(23.1) 6	(43.5) 10	(32.7) 16	(30.5) 18	(28.2) 11	(29.6) 29	(37.8) 28	(25.5) 13	(32.8) 41	(26.5) 9	(21.1) 4	(24.5) 13	(31.6) 61	(28.8) 38	(30.5) 99
2. Disoriented Bizarre Behavior	-	-	-	(1.7) 1	-	(1.0) 1	-	(2.0) 1	(0.8) 1	-	-	-	(0.5) 1	(0.8) 1	(0.6) 2
3. Self-Oriented Disturbance	(7.7) 2	(4.3) 1	(6.1) 3	(10.2) 6	(7.7) 3	(9.2) 9	(17.6) 13	(11.8) 6	(15.2) 19	(20.6) 7	(26.3) 5	(22.6) 12	(14.5) 28	(11.4) 15	(13.2) 43
4. Family/Marital Maladjustment	(42.3) 11	(17.4) 4	(30.6) 15	(23.7) 14	(28.2) 11	(25.5) 25	(10.8) 8	(41.2) 21	(23.2) 29	(17.6) 6	(31.6) 6	(22.6) 12	(20.2) 39	(31.8) 42	(24.9) 81
5. Developmental Disorder	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6. Other	-	(4.3) 1	(2.0) 1	(3.4) 2	-	(2.0) 2	(4.1) 3	-	(2.4) 3	(2.9) 1	-	(1.9) 1	(3.1) 6	(0.8) 1	(2.2) 7
0. Not Given	(26.9) 7	(30.4) 7	(28.6) 14	(30.5) 18	(35.9) 14	(32.7) 32	(29.7) 22	(19.6) 10	(25.6) 32	(32.4) 11	(21.1) 4	(28.3) 15	(30.1) 58	(26.5) 35	(28.6) 93
TOTAL	(100.0) 26	(99.9) 23	(100.0) 49	(100.0) 59	(100.0) 39	(100.0) 98	(100.0) 74	(100.1) 51	(100.0) 125	(100.0) 34	(100.1) 19	(99.9) 53	(100.0) 193	(100.1) 132	(100.0) 325

TABLE 22 (cont.)

REASON FOR REFERRAL	Row Totals														
	0 - 4			5 - 9			10 - 14			15 - 19			0 - 19		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
1. Social Disruptive Behavior	(35.4) 17	(42.9) 18	(38.9) 35	(30.6) 55	(33.8) 27	(31.5) 82	(38.3) 100	(27.7) 38	(34.7) 138	(36.4) 75	(22.7) 42	(29.9) 117	(35.5) 247	(28.2) 125	(32.7) 372
2. Disoriented Bizarre Behavior	(2.1) 1	-	(1.1) 1	(0.6) 1	(1.3) 1	(0.8) 2	(0.8) 2	(0.7) 1	(0.8) 3	(4.9) 10	(1.1) 2	(3.1) 12	(2.0) 14	(0.9) 4	(1.6) 18
3. Self Oriented Disturbance	(6.3) 3	(7.1) 3	(6.7) 6	(13.3) 24	(8.8) 7	(11.9) 31	(20.7) 54	(21.9) 30	(21.1) 84	(30.1) 62	(48.6) 90	(38.9) 152	(20.6) 143	(29.3) 130	(24.0) 273
4. Family/Marital Maladjustment	(25.0) 12	(9.5) 4	(17.8) 16	(11.7) 21	(16.3) 13	(13.1) 34	(9.2) 24	(19.7) 27	(12.8) 51	(7.3) 15	(16.8) 31	(11.8) 46	(10.4) 72	(16.9) 75	(12.9) 147
5. Developmental Disorder	(10.4) 5	(7.1) 3	(8.9) 8	(8.3) 15	(10.0) 8	(8.8) 23	(4.6) 12	(4.4) 6	(4.5) 18	(1.5) 3	(0.5) 1	(1.0) 4	(5.0) 35	(4.1) 18	(4.7) 53
6. Other	(2.1) 1	(4.8) 2	(3.3) 3	(11.1) 20	(2.5) 2	(8.5) 22	(9.6) 25	(8.0) 11	(9.0) 36	(4.4) 9	(1.6) 3	(3.1) 12	(7.9) 55	(4.1) 18	(6.4) 73
0. Not Given	(18.8) 9	(28.6) 12	(23.3) 21	(24.4) 44	(27.5) 22	(25.4) 66	(16.9) 44	(17.5) 24	(17.1) 68	(15.5) 32	(8.6) 16	(12.3) 48	(18.6) 129	(16.7) 74	(17.8) 203
TOTAL	(100.1) 48	(100.0) 42	(100.0) 90	(100.0) 180	(100.2) 80	(100.0) 260	(100.1) 261	(99.9) 137	(100.0) 398	(100.1) 206	(99.9) 185	(100.1) 391	(100.0) 695	(100.2) 444	(100.1) 1139

oriented disturbance accounts for 49 percent. For males, the respective figures are 36 percent for socially disruptive behaviour as opposed to 30 percent for self-oriented disturbance. In short, for older adolescents, males are likely to be referred because they are disturbing others, and females because they exhibit such behaviours as excessive passivity and shyness, over-conformity, day-dreaming, lack of self-confidence, and other "self-oriented disturbances".

Diagnostic Problems

Whatever the presenting problems, what are the formal diagnoses? "Diagnoses" is accurate, here, since patients/clients frequently receive multiple diagnoses whose relative prominence may vary over the course of treatment. Table 23 somewhat oversimplifies this complex diagnostic pattern by presenting only the primary diagnosis made at the time of outpatient registration.

Table 23 shows substantial variation among facilities in the frequency with which particular diagnostic categories are utilized. For example, facility 09 finds that "developmental delays" occur in 24.8 percent of all 0-19 age outpatients/clients, while facility 12 finds it occurs in .8 percent of cases. Even more disturbing is the fact that, overall, 24.7 percent of all patients/clients were diagnosed as "other". This category refers to quite vague diagnoses, such as "unspecified mental or behavioural problems". This large proportion of essentially undiagnosed patients is surprising given that recent years have seen considerable progress in the development of systematic, well-defined, minimally overlapping psychiatric diagnostic categories. The Department of Health follows the "Manual for the Classification of Mental Disorders" prepared by the Health Division of Statistics Canada and borrowed from the Ninth Revision of the International Classification of Diseases, Chapter V: Mental Disorders (ICD-9). Further revisions are in progress. Table 23 follows the ICD-9 codes but understates their complexity by

TABLE 23: DIAGNOSTIC IMPRESSION OF OUTPATIENTS, BY AGE GROUP AND FACILITY, 1981.[1, 2, 3]

	FACILITY				
			(01)		
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	(4.1) 5	(9.8) 19	(7.9) 7	(6.9) 31
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(3.4) 3	(0.7) 3
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	(9.3) 4	(2.5) 3	(0.5) 1	(1.1) 1	(2.0) 9
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	(4.6) 9	(5.6) 5	(3.1) 14
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	(4.1) 5	(8.8) 17	(6.7) 6	(6.3) 28
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(34.9) 15	(21.3) 26	(23.7) 46	(30.3) 27	(25.4) 114
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	(0.5) 1	-	(0.2) 1
Sexual Deviations and Disorders. 302	-	-	(0.5) 1	(1.1) 1	(0.4) 2

TABLE 23 (cont.)

FACILITY

(01)

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	(2.5) 3	(1.5) 3	(1.1) 1	(1.6) 7
Depressive Disorder, 311	-	-	(1.5) 3	(2.2) 2	(1.1) 5
Conduct Disorder, 312	(16.3) 7	(25.4) 31	(23.7) 46	(13.5) 12	(21.4) 96
Disturbance of emotions specific to childhood and adolescence 313	(7.0) 3	(16.4) 20	(13.4) 26	(7.9) 7	(12.5) 56
Hyperkinesis 314	(9.3) 4	(4.9) 6	-	-	(2.2) 10
Developmental Delays 315	(14.0) 6	(5.7) 7	(1.0) 2	-	(3.3) 15
Mental Retardation 317, 318, 319	(4.7) 2	(5.7) 7	(2.6) 5	(2.2) 2	(3.6) 16
Personality Disorder 301	-	-	(1.5) 3	(5.6) 5	(1.8) 8
Other	(4.7) 2	(7.4) 9	(6.2) 12	(11.2) 10	(7.4) 33
Total	(100.2) 43	(100.0) 122	(99.8) 194	(99.8) 89	(99.9) 448

TABLE 23 (cont.)

Diagnosis	FACILITY (02) 0 - 4	 5 - 9	 10 - 14	 15 - 19	 0 - 19
Neurotic Disorders 300	-	(2.7) 1	(4.7) 3	(2.7) 2	(3.3) 6
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(2.7) 2	(1.1) 2
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	-	-
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	-	-	-	-
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(50.0) 4	(29.7) 11	(46.9) 30	(67.1) 49	(51.6) 94
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	-	-
Sexual Deviations and Disorders. 302	-	-	-	-	-

TABLE 23 (cont.)

FACILITY

	(02)				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	-	-
Depressive Disorder, 311	(12.5) 1	-	(1.6) 1	(2.7) 2	(2.2) 4
Conduct Disorder, 312	-	(8.1) 3	(18.8) 12	(15.1) 11	(14.3) 26
Disturbance of emotions specific to childhood and adolescence 313	-	-	-	-	-
Hyperkinesis 314	(37.5) 3	(2.7) 1	(4.7) 3	-	(3.8) 7
Developmental Delays 315	-	(45.9) 17	(15.6) 10	(4.1) 3	(16.5) 30
Mental Retardation 317, 318, 319	-	(8.1) 3	(7.8) 5	(2.7) 2	(5.5) 10
Personality Disorder 301	-	-	-	(1.4) 1	(0.5) 1
Other	-	(2.7) 1	-	(14.) 1	(1.1) 2
Total	(100.0) 8	(99.9) 37	(100.1) 64	(99.9) 73	(99.9) 182

TABLE 23 (cont.)

			FACILITY (03)		
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	-	-	(17.6) 15	(17.4) 15
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(16.5) 14	(16.3) 14
Other Non-Organic Psychoses 298	-	-	-	(1.2) 1	(1.2) 1
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	(4.7) 4	(4.7) 4
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	-	-	-	-
Acute Reaction to Stress. Adjustment Reaction. 308, 309	-	-	(100.0) 1	(12.9) 11	(14.0) 12
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	-	-
Sexual Deviations and Disorders. 302	-	-	-	(3.5) 3	(3.5) 3

TABLE 23 (cont.)

FACILITY

(03)

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	-	-
Depressive Disorder, 311	-	-	-	(1.2) 1	(1.2) 1
Conduct Disorder, 312	-	-	-	(2.4) 2	(2.4) 2
Disturbance of emotions specific to childhood and adolescence 313	-	-	-	-	-
Hyperkinesis 314	-	-	-	-	-
Developmental Delays 315	-	-	-	-	-
Mental Retardation 317, 318, 319	-	-	-	(3.5) 3	(3.5) 3
Personality Disorder 301	-	-	-	(31.8) 27	(31.4) 27
Other	-	-	-	(4.7) 4	(4.7) 4
Total	-	-	(100.0) 1	(100.0) 85	(100.2) 86

TABLE 23 (cont.)

			FACILITY (04)		
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	-	-	(5.5) 7	(3.6) 7
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	(2.0) 1	(8.7) 11	(6.2) 12
Other Non-Organic Psychoses 298	-	-	-	(1.6) 2	(1.0) 2
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	(3.9) 5	(2.6) 5
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	-	-	-	-
Acute Reaction to Stress. Adjustment Reaction. 308, 309	-	(28.6) 4	(23.5) 12	(30.7) 39	(28.5) 55
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	(1.6) 2	(1.0) 2
Sexual Deviations and Disorders. 302	-	-	-	(0.8) 1	(0.5) 1

TABLE 23 (cont.)

	FACILITY				
		(04)			
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	(0.8) 1	(0.5) 1
Depressive Disorder, 311	-	(7.1) 1	-	(4.7) 6	(3.6) 7
Conduct Disorder, 312	-	(35.7) 5	(58.8) 30	(23.6) 30	(33.7) 65
Disturbance of emotions specific to childhood and adolescence 313	-	-	-	(0.8) 1	(0.5) 1
Hyperkinesis 314	-	(21.4) 3	(2.0) 1	(0.8) 1	(2.6) 5
Developmental Delays 315	-	-	(5.9) 3	(2.4) 3	(3.1) 6
Mental Retardation 317, 318, 319	-	(7.1) 1	0	(1.6) 2	(1.6) 3
Personality Disorder 301	(100.0) 1	-	-	(9.4) 12	(6.7) 13
Other	-	-	(7.8) 4	(3.9) 5	(4.7) 9
Total	(100.0) 1	(99.9) 14	(100.0) 51	(100.0) 127	(99.9) 193

TABLE 23 (cont.)

	FACILITY (OS)				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	(6.3) 4	(9.6) 5	(10.6) 10	(8.6) 19
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	(1.6) 1	-	(6.4) 6	(3.2) 7
Other Non-Organic Psychoses 298	-	-	-	(1.1) 1	(0.5) 1
Childhood Psychoses 299	-	(1.6) 1	-	-	(0.5) 1
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	(1.1) 1	(0.5) 1
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	(1.6) 1	-	-	(0.5) 1
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(30.0) 3	(39.1) 25	(26.9) 14	(28.7) 27	(31.4) 69
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	(1.9) 1	(2.1) 2	(1.4) 3
Sexual Deviations and Disorders. 302	-	-	-	-	-

TABLE 23 (cont.)

FACILITY

(05)

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	-	-
Depressive Disorder, 311	-	-	(1.9) 1	(2.1) 2	(1.4) 3
Conduct Disorder, 312	-	(9.4) 6	(28.8) 15	(20.2) 19	(18.2) 40
Disturbance of emotions specific to childhood and adolescence 313	(10.0) 1	(3.1) 2	(3.8) 2	-	(2.3) 5
Hyperkinesis 314	-	(4.7) 3	(1.9) 1	-	(1.8) 4
Developmental Delays 315	(10.0) 1	(9.4) 6	(5.8) 3	(5.3) 5	(6.8) 15
Mental Retardation 317, 318, 319	-	(6.3) 4	(3.8) 2	(5.3) 5	(5.0) 11
Personality Disorder 301	-	-	-	(9.6) 9	(4.1) 9
Other	(50.0) 5	(17.2) 11	(15.4) 8	(7.4) 7	(14.1) 31
Total	(100.0) 10	(100.3) 64	(99.8) 52	(99.9) 94	(100.3) 220

TABLE 23 (cont.)

	FACILITY				
	(06)				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	(12.0) 3	(7.3) 3	(6.0) 4	(6.9) 10
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(4.5) 3	(2.1) 3
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	-	-
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	(4.0) 1	(2.4) 1	(1.5) 1	(2.1) 3
Acute Reaction to Stress. Adjustment Reaction. 308, 309	-	(8.0) 2	(29.3) 12	(34.3) 23	(25.7) 37
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	-	-
Sexual Deviations and Disorders. 302	-	-	-	-	-

TABLE 23 (cont.)

FACILITY

(06)

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	(4.0) 1	-	-	(0.7) 1
Depressive Disorder, 311	-	-	(2.4) 1	(3.0) 2	(2.1) 3
Conduct Disorder, 312	(9.1) 1	(32.0) 8	(34.1) 14	(14.9) 10	(22.9) 33
Disturbance of emotions specific to childhood and adolescence 313	(27.3) -	(16.0) 2	(4.9) 1	-	(6.3) 3
Hyperkinesis 314	(9.1) 3	(4.0) 4	(2.4) 2	-	(2.1) 3
Developmental Delays 315	(9.1) 1	(4.0) 1	(2.4) 1	-	(2.1) 3
Mental Retardation 317, 318, 319	-	-	-	(3.0) 2	(1.4) 2
Personality Disorder 301	(9.1) 1	-	(7.3) 3	(20.9) 14	(12.5) 18
Other	(45.5) 5	(12.0) 3	(7.3) 3	(11.9) 8	(13.2) 19
Total	(100.1) 11	(100.0) 25	(99.8) 41	(100.0) 67	(100.1) 144

TABLE 23 (cont.)

	FACILITY				
	(07)				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	-	(6.7) 3	(7.9) 3	(5.4) 6
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(2.6) 1	(0.9) 1
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	-	-
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	-	(2.2) 1	(2.6) 1	(1.8) 2
Acute Reaction to Stress. Adjustment Reaction. 308, 309	-	(16.0) 4	(40.0) 18	(47.4) 18	(36.0) 40
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	(2.6) 1	(0.9) 1
Sexual Deviations and Disorders. 302	-	-	-	-	-

TABLE 23 (cont.)

FACILITY

	(07)				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	-	-
Depressive Disorder, 311	-	-	-	(2.6) 1	(0.9) 1
Conduct Disorder, 312	-	(28.0) 7	(15.6) 7	(7.9) 3	(15.3) 17
Disturbance of emotions specific to childhood and adolescence 313	-	-	(4.4) 2	-	(1.8) 2
Hyperkinesis 314	-	(12.0) 3	(6.7) 3	-	(5.4) 6
Developmental Delays 315	(100.0) 3	(12.3) 3	(6.7) 3	-	(8.1) 9
Mental Retardation 317, 318, 319	-	-	(4.4) 2	(5.3) 2	(3.6) 4
Personality Disorder 301	-	-	-	(13.2) 5	(4.5) 5
Other	-	(32.0) 8	(13.3) 6	(7.9) 3	(15.3) 17
Total	(100.0) 3	(100.0) 25	(100.0) 45	(100.0) 38	(99.9) 111

TABLE 23 (cont.)

	FACILITY				
	(08)				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	(40.0) 2	(10.0) 1	(8.3) 4	(24.6) 15	(17.7) 22
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	(2.1) 1	(1.6) 1	(1.6) 2
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	-	-
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	-	(4.2) 2	-	(1.6) 2
Acute Reaction to Stress. Adjustment Reaction. 308, 309	-	(10.0) 1	(22.9) 11	(21.3) 13	(20.2) 25
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	-	-
Sexual Deviations and Disorders. 302	-	-	-	(1.6) 1	(0.8) 1

TABLE 23 (cont.)

FACILITY

			(08)		
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	-	-
Depressive Disorder, 311	-	-	-	(3.3) 2	(1.6) 2
Conduct Disorder, 312	(20.0) 1	(40.0) 4	(31.3) 15	(6.6) 4	(19.4) 24
Disturbance of emotions specific to childhood and adolescence 313	-	-	-	-	-
Hyperkinesis 314	-	-	-	-	-
Developmental Delays 315	(40.0) 2	-	(10.4) 5	(1.6) 1	(6.5) 8
Mental Retardation 317, 318, 319	-	-	-	(1.6) 1	(0.8) 1
Personality Disorder 301	-	-	(2.1) 1	(18.0) 11	(9.7) 12
Other	-	(40.0) 4	(18.8) 9	(19.7) 12	(20.2) 25
Total	(100.0) 5	(100.0) 10	(100.1) 48	(99.9) 61	(100.1) 124

TABLE 23 (cont.)

FACILITY

(09)

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	(6.5) 4	(11.3) 8	(24.3) 17	(13.1) 29
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(2.9) 2	(0.9) 2
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	(1.4) 1	(2.9) 2	(1.4) 3
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	(5.3) 1	(4.8) 3	(1.4) 1	-	(2.3) 5
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(5.3) 1	(9.7) 6	(18.3) 13	(35.7) 25	(20.3) 45
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	(1.4) 1	-	(0.5) 1
Sexual Deviations and Disorders. 302	-	-	-	-	-

TABLE 23 (cont.)

FACILITY

			(09)		
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	-	-
Depressive Disorder, 311	-	-	-	(7.1) 5	(2.3) 5
Conduct Disorder, 312	(15.8) 3	(12.9) 8	(15.5) 11	(4.3) 3	(11.3) 25
Disturbance of emotions specific to childhood and adolescence 313	(10.5) 2	(4.8) 3	(5.6) 4	-	(4.1) 9
Hyperkinesis 314	(5.3) 1	(3.2) 2	(2.8) 2	-	(2.3) 5
Developmental Delays 315	(15.8) 3	(38.7) 24	(31.0) 22	(8.6) 6	(24.8) 55
Mental Retardation 317, 318, 319	(15.8) 3	(8.1) 5	(2.8) 2	(1.4) 1	(5.0) 11
Personality Disorder 301	-	-	-	(8.6) 6	(2.7) 6
Other	(26.3) 5	(11.3) 7	(8.5) 6	(4.3) 3	(9.5) 21
Total	(100.1) 19	(100.0) 62	(100.0) 71	(100.1) 70	(100.5) 222

TABLE 23 (cont.)

	FACILITY				
	(10)				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	-	(2.9) 3	(1.8) 2	(1.7) 5
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(0.9) 1	(0.3) 1
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	(0.9) 1	(0.3) 1
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	(1.4) 1	(1.0) 1	-	(0.7) 1
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(66.7) 6	(69.6) 48	(54.8) 57	(47.7) 52	(56.0) 163
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	-	-
Sexual Deviations and Disorders. 302	-	-	-	-	-

TABLE 23 (cont.)

FACILITY

(10)

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	(0.9) 1	(0.3) 1
Depressive Disorder, 311	-	-	-	(2.8) 3	(1.0) 3
Conduct Disorder, 312	-	(1.4) 1	(2.9) 3	(5.5) 6	(3.4) 10
Disturbance of emotions specific to childhood and adolescence 313	-	-	(1.0) 1	-	(0.3) 1
Hyperkinesis 314	-	(2.9) 2	(2.9) 3	-	(1.7) 5
Developmental Delays 315	(11.1) 1	(2.9) 2	(1.9) 2	(1.8) 2	(2.4) 7
Mental Retardation 317, 318, 319	-	(5.8) 4	(1.0) 1	(9.2) 10	(5.2) 15
Personality Disorder 301	-	-	-	(5.5) 6	(2.1) 6
Other	(22.2) 2	(15.9) 11	(31.7) 33	(22.9) 25	(24.4) 71
Total	(100.0) 9	(99.9) 69	(100.1) 104	(99.9) 109	(99.8) 291

TABLE 23 (cont.)

			FACILITY (11)		
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	-	-	(8.0) 4	(2.2) 4
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(2.0) 1	(0.6) 1
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	(2.0) 1	(0.6) 1
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	-	-	-	-
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(23.1) 3	(22.6) 12	(14.5) 9	(34.0) 17	(23.0) 41
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	-	-
Sexual Deviations and Disorders. 302	-	-	-	-	-

TABLE 23 (cont.)

FACILITY

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
		(11)			
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	-	-
Depressive Disorder, 311	-	-	-	-	-
Conduct Disorder, 312	-	-	-	(2.0) 1	(0.6) 1
Disturbance of emotions specific to childhood and adolescence 313	-	-	-	-	-
Hyperkinesis 314	-	-	-	-	-
Developmental Delays 315	(23.1) 3	(7.5) 4	(1.6) 1	(2.0) 1	(5.1) 9
Mental Retardation 317, 318, 319	-	(3.8) 2	(3.2) 2	(6.0) 3	(3.9) 7
Personality Disorder 301	-	-	(3.2) 2	(8.0) 4	(3.4) 6
Other	(53.8) 7	(66.0) 35	(77.4) 48	(36.0) 18	(60.7) 108
Total	(100.0) 13	(99.9) 53	(99.9) 62	(100.0) 50	(100.1) 178

TABLE 23 (cont.)

	FACILITY (12)				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	-	(3.7) 2	(4.3) 3	(6.7) 7	(4.8) 12
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	(2.9) 3	(1.2) 3
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	(5.0) 1	-	-	(1.0) 1	(0.8) 2
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	-	(1.9) 1	-	-	(0.4) 1
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(10.0) 2	(16.7) 9	(38.6) 27	(45.7) 48	(34.5) 86
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-	-	-
Sexual Deviations and Disorders. 302	-	-	-	-	-

TABLE 23 (cont.)

FACILITY

(12)

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	(1.4) 1	-	(0.4) 1
Depressive Disorder, 311	-	-	-	-	-
Conduct Disorder, 312	(10.0) 2	(11.1) 6	(5.7) 4	(2.9) 3	(6.0) 15
Disturbance of emotions specific to childhood and adolescence 313	-	-	-	-	-
Hyperkinesis 314	(5.0) 1	(1.9) 1	-	-	(0.8) 2
Developmental Delays 315	(5.0) 1	-	(1.4) 1	-	(0.8) 2
Mental Retardation 317, 318, 319	-	(1.9) 1	-	-	(0.4) 1
Personality Disorder 301	-	-	-	(1.9) 2	(0.8) 2
Other	(65.0) 13	(63.0) 34	(48.6) 34	(39.0) 41	(49.0) 122
Total	(100.0) 20	(100.2) 54	(100.0) 70	(100.1) 105	(99.9) 249

TABLE 23 (cont.)

	FACILITY				
			(13)		
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	(2.3) 3	(1.9) 6	(5.8) 20	(6.8) 10	(4.2) 39
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	-	-	-	-
Other Non-Organic Psychoses 298	-	-	-	-	-
Childhood Psychoses 299	-	-	-	-	-
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	-	-	-	-	-
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	(4.5) 6	(2.3) 7	(0.9) 3	-	(1.7) 16
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(36.1) 48	(45.5) 141	(34.3) 119	(24.7) 36	(36.8) 344
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	(0.3) 1	-	(0.1) 1
Sexual Deviations and Disorders. 302	-	-	-	(0.7) 1	(0.1) 1

TABLE 23 (cont.)

FACILITY

(13)

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	-	-	(0.7) 1	(0.1) 1
Depressive Disorder, 311	-	-	(0.9) 3	(2.1) 3	(0.6) 6
Conduct Disorder, 312	(7.5) 10	(10.3) 32	(12.7) 44	(13.7) 20	(11.1) 104
Disturbance of emotions specific to childhood and adolescence 313	-	(0.6) 2	(1.2) 4	(5.5) 8	(1.5) 14
Hyperkinesis 314	(1.5) 2	(0.6) 2	(0.3) 1	-	(0.5) 5
Developmental Delays 315	-	(1.0) 3	(1.7) 6	(1.4) 2	(1.2) 11
Mental Retardation 317, 318, 319	-	-	(0.6) 2	-	0.2) 2
Personality Disorder 301	-	(0.3) 1	(1.7) 6	(6.2) 9	(1.7) 16
Other	(48.1) 64	(37.4) 116	(39.8) 138	(38.4) 56	(40.0) 374
Total	(100.0) 133	(99.9) 310	(100.2) 347	(100.2) 146	(99.8) 936

TABLE 23 (cont.)

	FACILITY				
	ROW TOTALS				
Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders 300	(1.8) 5	(3.1) 26	(6.2) 71	(9.2) 103	(6.1) 205
Psychoses (schizophrenia, affective psychoses, paranoid states) 295, 296, 297	-	(0.1) 1	(0.2) 2	(4.3) 48	(1.5) 51
Other Non-Organic Psychoses 298	-	-	-	(0.4) 4	(0.1) 4
Childhood Psychoses 299	(1.5) 4	(0.5) 4	(0.1) 1	(0.1) 1	(0.3) 10
Alcohol & other Drug Abuse, Dependence & Psychoses 291, 292, 293 303, 304, 305	(0.4) 1	-	(0.9) 10	(1.8) 20	(0.9) 31
Special Symptoms: tics, stuttering, psychalgia, anorexia nervosa 307	(2.5) 7	(2.2) 19	(2.3) 26	(0.7) 8	(1.8) 60
Acute Reaction to Stress. Adjustment Reaction. 308, 309	(29.8) 82	(34.2) 289	(32.1) 369	(34.6) 385	(33.2) 1125
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	(0.3) 4	(0.4) 5	(0.3) 9
Sexual Deviations and Disorders. 302	-	-	(0.1) 1	(0.6) 7	(0.2) 8

TABLE 23 (cont.)

FACILITY

ROW TOTALS

Diagnosis	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	-	(0.5) 4	(0.3) 4	(0.3) 3	(0.3) 11
Depressive Disorder, 311	(0.4) 1	(0.1) 1	(0.8) 9	(2.6) 29	(1.2) 40
Conduct Disorder, 312	(8.7) 24	(13.1) 111	(17.5) 201	(11.1) 124	(13.6) 460
Disturbance of emotions specific to childhood and adolescence 313	(2.2) 6	(3.4) 29	(3.5) 40	(1.4) 16	(2.7) 91
Hyperkinesis 314	(5.1) 14	(3.2) 27	(1.4) 16	(0.1) 1	(1.7) 58
Developmental Delays 315	(7.6) 21	(7.9) 67	(5.1) 59	(2.1) 23	(5.0) 170
Mental Retardation 317, 318, 319	(1.8) 5	(3.2) 27	(.1.8) 21	(3.0) 33	(2.5) 86
Personality Disorder 301	(0.7) 2	(0.1) 1	(1.3) 15	(10.0) 111	(3.8) 129
Other	(37.5) 103	(28.3) 239	(26.2) 301	(17.3) 193	(24.7) 836
Total	(100.0) 275	(99.9) 845	(100.1) 1150	(100.0) 1114	(99.9) 3384

1. The category "other" includes primarily vague diagnoses such as N71.0 "observation for suspected mental condition" and 799 - "other ill-defined and unknown causes of morbidity and mortality".
2. Numbers in brackets are percentages of column totals.
3. These data were collected from the outpatient registration form.

omitting a decimal which permits much finer diagnostic classification. The table also makes for additional imprecision by collapsing some categories in an effort to avoid too many empty or nearly empty cells.

Accurate diagnosis is essential for proper treatment planning, for communicating efficiently with other mental health staff members and (in the aggregate as an index of the prevalence of specific disorders) as an essential datum for program planning at the level of the mental health care delivery system as a whole. This Study therefore will recommend that mental health staff be provided with uniform training in the use of psychiatric diagnostic categories. (This topic will be returned to in Chapter XII.)

Young mental health outpatients are frequently referred to the Izaak Walton Killam Hospital, whose staff often finds the original diagnoses to have been somewhat inaccurate. A senior mental health staff member at the I.W.K. Hospital was asked to interpret table 23 on the basis of the pattern of re-diagnoses which the hospital often finds it necessary to make. That professional felt that the most frequent outpatient diagnostic category, "reaction to stress/adjustment reaction" (ICD-9 308, 309) tends to be over-used, a "grab-bag". At the same time, developmental delays, mental retardation, and disturbances of emotions specific to childhood and adolescence appeared to be under-diagnosed.

Some child mental health experts consulted suggested that there is a tendency among family physicians and mental health staff to fail to recognize early developmental delay and instead suggest to the parents that their child "will grow out of it". Sometimes children will indeed "grow out of" early problems. But if the physician or other professional is not scrupulous in seeing such children for follow-up visits then it may be that some serious problems will go untreated until at least school age: and in children (as child experts never weary of repeating), the earlier treated the better. The I.W.K. Hospital consultant suggested that the sharp jump in the outpatient mental health population that occurs between the 0-4 and 5-9 age groups indicates that only with school entry are many children's problems revealed, including perhaps problems that physicians believed the child would "grow out of".

Another area of under-diagnosis suggested by the I.W.K. Hospital staff member consulted may be hyperkinesis in the 15-19 age group. Hyperkinesis is no longer believed by mental health experts to be something one necessarily "outgrows" but many family physicians and out-patient mental health staff are unaware of this change in consensus. Thus, hyperkinetic teenagers, it was suggested, are likely to be diagnosed as "conduct disorders".

The I.W.K. expert consulted also suggested that the number of those diagnosed as suffering from functional psychoses appeared to be low, possibly indicating that young psychotics may be receiving poor after-care.

Lay people tend to think of mental health facilities as treating people who are "crazy", that is, psychotic. What proportion of out-patients in the 0-19 age group suffered, in 1981, from psychoses? If we add together schizophrenia, paranoid states and childhood psychoses, and organic brain damage regardless of whether it actually leads to psychotic behaviour (that is, if we add together ICD-9 295, 296, 298, 299, 294, 310), we still find that they account for only 2.3 percent of mental health outpatients. If we further add alcohol and other drug abuse, dependence and psychosis (291, 292, 293, 303, 304, 305) we still only total 3.2 percent of outpatients. In short, only a very small percentage of young mental health outpatients being seen are psychotic or brain damaged: the vast majority suffer from much less grave problems.

Table 23 shows that conduct disorder and personality disorder interact with age in an unusual manner. Conduct disorder peaks in frequency with the 10-14 age group. On the other hand, personality disorder is only 1.3 percent for the 10-14 age group but jumps to ten percent for the 15-19 age group. One mental health professional suggested that there is a strong reluctance to diagnose a child as suffering from a personality disorder — a serious psychiatric illness —and thus younger patients tend to be assigned to the "conduct disorder" category. But the reluctance to make a diagnosis of personality disorder seems to wane by the time the patient reaches the 15-19 year old category, so we see personality disorder appear to increase sharply while conduct disorder drops correspondingly.

Psychiatric advisors to this Study suggested that the very small number of cases of "depressive disorder" (311) indicated meant only that family physicians and mental health staff have not yet learned to recognize this disorder in children and adolescents. Instead, they are likely to diagnose depression as "adjustment reaction" and "reaction to stress" (308-309). The present consensus among pediatric and general psychiatrists is that childhood and adolescent depression is actually a serious but often undiagnosed and untreated disorder.

At least a substantial portion of "adjustment reaction" and "reaction to stress" must nevertheless represent accurate diagnosis. If so, this fact has important implications for the relationship between mental health and other types of facilities responsible for young people. "Acute reaction to stress" is defined in the ICD-9 manual as:

> Very transient disorders of any severity and nature which occur in individuals without any apparent mental disorder in response to exceptional physical or mental stress, such as natural catastrophe or battle, and which usually subside within hours or days (p. 38).

"Adjustment reaction" is defined in part as:

> Mild or transient disorders lasting longer than acute stress reactions which occur in individuals of any age without any apparent pre-existing disorder. Such disorders are often relatively circumscribed or situation-specific, are generally reversible, and usually last only a few months. They are usually closely related in time and content to stresses such as bereavement...(p. 39).

To the extent that outpatient mental health facilities are accurately diagnosing "acute reation to stress" and "adjustment reaction", to that extent they and social service agencies are overlapping in function. Presumably, young people suffering from these life problems might also be "treated"—or already have been "treated"—by a clergyman, a grandparent or family friend, a social worker or psychologist in private practice, or at a facility funded by the Department of Social Services. Presumably, too, the most severely troubled "acute reaction to stress" and "adjustment reaction" patients are eventually referred to mental health facilities, along with many less troubled.

The point here is to emphasize the extent to which social service and mental health services form a continuum. The implication is clear: these services must cooperate not occasionally but intimately. Mental health and social service agencies overlap substantially in function, a fact easily overlooked (as was discussed in Chapter III) by administrators who stress that one is "health" and the other "social service" in nature and funding.

Overall, the results shown in table 23 are not dissimilar from Jacobson et al.'s (1980) study of four American child/adolescent mental health facilities. That study found the most common mental disorders in an under-18 population to be "transient situational disturbances", followed by behaviour disorder and then by special symptoms. Severe illnesses — psychoses and organic brain damage — made up less than 4 percent of diagnosed mental disorders. Table 23 finds (as was mentioned previously) that the severe disorders accounted for only 3.2 percent of outpatients, while the most common disorders (excluding "other") were acute reaction to stress/adjustment reaction, followed by conduct disorder and then by neurotic disorder.

To conclude discussion of table 23, it is important not to interpret its data as any indication of prevalence: We do not know the true prevalence of any of these mental disorders, only the frequency with which they are diagnosed by mental health facilities.

Psychiatric Inpatients

Table 24 deals with psychiatric inpatients in the 0-19 age group. The table provides data from the five specialized inpatient hospitals and (in aggregate form) from the regional hospitals. Only two of the five specialized hospitals, the Izaak Walton Killam (Children's) Hospital and the Nova Scotia (Psychiatric) Hospital actually have specific treatment programs and staff for children and adolescents. Other psychiatric and general hospitals admit older adolescents into adult beds. When they do admit a younger psychiatric patient (often an emergency admission), they tend either to discharge the patient quickly or else to separate the patient to the I.W.K. or N.S. hospitals. It is to these two hospitals, therefore, that most of the following data pertain. However, since these two institutions are discussed at length in Chapter VIII ("Special Problems of the Metro Area"), the present exposition will emphasize those data which pertain to the Province as a whole. Finally, since the hospitals involved are so few in number, it would be pointless to pretend that the use of code numbers, followed in the analysis of outpatient data, would here serve any purpose.

Table 24 differs from table 23 in that the latter dealt with outpatients and the former deals with inpatients. One difference is immediately apparent: the inpatient data lack the diagnostic category "other", suggesting that reluctance to label and perhaps lack of familiarity with diagnostic categories is not here a problem. Another important difference is that, while acute reaction to stress/adjustment reaction, "other", and conduct disorder were the three most frequently used categories for outpatients, for inpatients they are (in order) mental retardation, neurotic disorders, and developmental delays.

For each age group we find particular problems are salient. For the 0-4 group, developmental delays account for 44.4 percent of all inpatients, with mental retardation accounting for an additional 29.8 percent. For the 5-9 age group, mental retardation accounts for 26.3 percent, developmental delays for 23.7 percent, special symptoms for 17.5 percent, and conduct disorders for 16.0 percent. For the 10-14 age group, neurotic disorders jump to 16.5 percent, conduct disorders fall only very slightly to 15.7 percent, special symptoms are 14.5 percent, mental retardation 14.0 percent, and acute reaction to stress adjustment reaction 13.6 percent. For the ages of 15-19, neurotic disorders are now 17.6 percent, acute reaction to stress/adjustment reaction 15.6 percent, and personality disorder 11.8 percent.

Table 24

PRIMARY DIAGNOSIS, BY AGE GROUP AND FACILITY, FOR ALL PSYCHIATRIC INPATIENT ADMISSIONS, 1981.

Facility: Cape Breton Hospital

DIAGNOSIS	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders. 300.	-	-	-	-	-
Psychoses (schizophrenia, affective psychoses and paranoid states). 295, 296, 297.	-	-	-	(15.4) 4	(14.8) 4
Other Non-Organic Psychoses. 298.	-	-	-	-	-
Childhood Psychoses. 299.	-	-	-	-	-
Alcohol and Other Drug Abuse, Dependence and Psychoses. 291, 292, 293, 303, 304, 305.	-	-	-	(11.5) 3	(11.1) 3
Special Symptons: e.g. tics, stuttering, psychaligia, anorexia nervosa. 307.	-	-	-	-	-
Acute Reaction to Stress Adjustment Reaction. 308, 309.	-	-	-	(3.8) 1	(3.7) 1
Organic Psychotic Conditions, Non-Psychotic Disorders following Brain Damage. 294, 310.	-	-	-	-	-
Sexual Deviations and Disorders. 302.	-	-	-	-	-
Physiological Malfunction from Mental Factors, Psychic Factors Associated with Diseases elsewhere Classified. 306, 316.	-	-	-	-	-
Depressive Disorder. 311.	-	(100.0) 1	-	(3.8) 1	(7.4) 2
Conduct Disorder. 312.	-	-	-	(11.5) 3	(11.1) 3
Disturbance of Emotions Specific to Childhood and Adolescence. 313.	-	-	-	-	-
Hyperkinesis. 314.	-	-	-	-	-
Developmental Delays. 315.	-	-	-	-	-
Mental Retardation. 317, 318, 319.	-	-	-	(7.7) 2	(7.4) 2
Personality Disorder. 301.	-	-	-	(46.2) 12	(44.4) 12
TOTAL	-	(100.0) 1	-	(99.9) 26	(99.9) 27

Table 24 (cont.)

FACILITY: ABBIE J. LANE

DIAGNOSIS	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders. 300.	-	-	-	-	-
Psychoses (schizophrenia, affective psychoses and paranoid states). 295, 296, 297.	(100.0) 1	-	-	(66.7) 4	(71.4) 5
Other Non-Organic Psychoses. 298.	-	-	-	-	-
Childhood Psychoses. 299.	-	-	-	-	-
Alcohol and Other Drug Abuse, Dependence and Psychoses. 291, 292, 293, 303, 304, 305.	-	-	-	-	-
Special Symptons: e.g. tics, stuttering, psychaligia, anorexia nervosa. 307.	-	-	-	-	-
Acute Reaction to Stress Adjustment Reaction. 308, 309.	-	-	-	-	-
Organic Psychotic Conditions, Non-Psychotic Disorders following Brain Damage. 294, 310.	-	-	-	-	-
Sexual Deviations and Disorders. 302.	-	-	-	-	-
Physiological Malfunction from Mental Factors, Psychic Factors Associated with Diseases elsewhere Classified. 306, 316.	-	-	-	-	-
Depressive Disorder. 311.	-	-	-	-	-
Conduct Disorder. 312.	-	-	-	-	-
Disturbance of Emotions Specific to Childhood and Adolescence. 313.	-	-	-	-	-
Hyperkinesis. 314.	-	-	-	-	-
Developmental Delays. 315.	-	-	-	-	-
Mental Retardation. 317, 318, 319.	-	-	-	-	-
Personality Disorder. 301.	-	-	-	(33.3) 2	(28.5) 2
TOTAL	(100.0) 1	-	-	(100.0) 6	(100.0) 7

Table 24 (cont.)

FACILITY: NOVA SCOTIA HOSPITAL

DIAGNOSIS	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders. 300.	-	-	(3.1) 1	(5.8) 11	(5.1) 12
Psychoses (schizophrenia, affective psychoses and paranoid states). 295, 296, 297.	-	-	(3.1) 1	(13.1) 25	(11.0) 26
Other Non-Organic Psychoses. 298.	-	(7.1) 1	-	(4.7) 9	(4.2) 10
Childhood Psychoses. 299.	-	-	(3.1) 1	-	(0.4) 1
Alcohol and Other Drug Abuse, Dependence and Psychoses. 291, 292, 293, 303, 304, 305.	-	-	(3.1) 1	(12.6) 24	(10.5) 25
Special Symptons: e.g. tics, stuttering, psychaligia, anorexia nervosa. 307.	-	-	-	-	-
Acute Reaction to Stress Adjustment Reaction. 308, 309.	-	-	(15.6) 5	(19.9) 38	(18.1) 43
Organic Psychotic Conditions, Non-Psychotic Disorders following Brain Damage. 294, 310.	-	-	-	(1.0) 2	(0.8) 2
Sexual Deviations and Disorders. 302.		-	-	(1.0) 2	(0.8) 2
Physiological Malfunction from Mental Factors, Psychic Factors Associated with Diseases elsewhere Classified. 306, 316.	-	-	-	-	-
Depressive Disorder. 311.	-	-	(3.1) 1	(3.7) 7	(3.4) 8
Conduct Disorder. 312.		(64.3) 9	(62.5) 20	(19.9) 38	(28.3) 67
Disturbance of Emotions Specific to Childhood and Adolescence. 313.	-	-	-	-	-
Hyperkinesis. 314.	-	(21.4) 3	(3.1) 1	(0.5) 1	(2.1) 5
Developmental Delays. 315.	-	-	-	-	-
Mental Retardation. 317, 318, 319.	-	(7.1) 1	(3.1) 1	(5.6) 1	(5.5) 1
Personality Disorder. 301.	-	-	-	(12.0) 23	(9.7) 23
TOTAL	-	(99.9) 14	(99.8) 32	(99.8) 191	(99.9) 237

Table 24 (cont.)

FACILITY: I.W.K. HOSPITAL

DIAGNOSIS	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders. 300.	-	(0.7) 1	(8.6) 11	(3.9) 2	(2.9) 14
Psychoses (schizophrenia, affective psychoses and paranoid states). 295, 296, 297.	-	-	-	(2.0) 1	(0.2) 1
Other Non-Organic Psychoses. 298.	-	-	-	(2.0) 1	(0.2) 1
Childhood Psychoses. 299.	(0.6) 1	(2.1) 3	(0.8) 1	-	(1.0) 5
Alcohol and Other Drug Abuse, Dependence and Psychoses. 291, 292, 293, 303, 304, 305.	-	(0.7) 1	(1.6) 2	(3.9) 2	(1.0) 5
Special Symptons: e.g. tics, stuttering, psychaligia, anorexia nervosa. 307.	(3.6) 6	(19.0) 27	(19.5) 25	(21.6) 11	(14.1) 69
Acute Reaction to Stress Adjustment Reaction. 308, 309.	-	(1.4) 2	(11.7) 15	(17.6) 9	(5.3) 26
Organic Psychotic Conditions, Non-Psychotic Disorders following Brain Damage. 294, 310.	-	-	-	(3.9) 2	(0.4) 2
Sexual Deviations and Disorders. 302.	-	-	-	-	-
Physiological Malfunction from Mental Factors, Psychic Factors Associated with Diseases elsewhere Classified. 306, 316.	(4.7) 8	(2.1) 3	(5.5) 7	-	(3.7) 18
Depressive Disorder. 311.	-	-	(0.8) 1	(2.0) 1	(0.4) 2
Conduct Disorder. 312.	(10.7) 18	(12.7) 18	(13.3) 17	(13.7) 7	(12.2) 60
Disturbance of Emotions Specific to Childhood and Adolescence. 313.	-	(1.4) 2	(3.1) 4	(2.0) 1	(1.4) 7
Hyperkinesis. 314.	(2.4) 4	(4.9) 7	(1.6) 2	-	(2.7) 13
Developmental Delays. 315.	(52.1) 88	(32.4) 46	(10.2) 13	(3.9) 2	(30.4) 149
Mental Retardation. 317, 318, 319.	(25.4) 43	(22.5) 32	(21.9) 28	(19.6) 10	(23.1) 113
Personality Disorder. 301.	(0.6) 1	-	(1.6) 2	(3.9) 2	(1.0) 5
TOTAL	(100.1) 169	(99.9) 142	(100.2) 128	(100.0) 51	(100.0) 490

Table 24 (cont.)

FACILITY: KINGS COUNTY REHABILITATION

DIAGNOSIS	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders. 300.	-	-	-	(25.0) 2	(25.0) 2
Psychoses (schizophrenia, affective psychoses and paranoid states). 295, 296, 297.	-	-	-	-	-
Other Non-Organic Psychoses. 298.	-	-	-	(37.5) 3	(37.5) 3
Childhood Psychoses. 299.	-	-	-	-	-
Alcohol and Other Drug Abuse, Dependence and Psychoses. 291, 292, 293, 303, 304, 305.	-	-	-	-	-
Special Symptons: e.g. tics, stuttering, psychaligia, anorexia nervosa. 307.	-	-	-	-	-
Acute Reaction to Stress Adjustment Reaction. 308, 309.	-	-	-	-	-
Organic Psychotic Conditions, Non-Psychotic Disorders following Brain Damage. 294, 310.	-	-	-	-	-
Sexual Deviations and Disorders. 302.	-	-	-	-	-
Physiological Malfunction from Mental Factors, Psychic Factors Associated with Diseases elsewhere Classified. 306, 316.	-	-	-	-	-
Depressive Disorder. 311.	-	-	-	-	-
Conduct Disorder. 312.	-	-	-	-	-
Disturbance of Emotions Specific to Childhood and Adolescence. 313.	-	-	-	-	-
Hyperkinesis. 314.	-	-	-	-	-
Developmental Delays. 315.	-	-	-	-	-
Mental Retardation. 317, 318, 319.	-	-	-	(25.0) 2	(25.0) 2
Personality Disorder. 301.	-	-	-	(12.5) 1	(12.5) 1
TOTAL	-	-	-	(100.0) 8	(100.0) 8

Table 24 (cont.)

NON-PSYCHIATRIC HOSPITALS

DIAGNOSIS	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders. 300.	(8.6) 3	(16.2) 6	(34.1) 28	(27.2) 98	(26.3) 135
Psychoses (schizophrenia, affective psychoses and paranoid states). 295, 296, 297.	-	-	-	(7.5) 27	(5.3) 27
Other Non-Organic Psychoses. 298.	(2.9) 1	-	(2.4) 2	(0.8) 3	(1.2) 6
Childhood Psychoses. 299.	(2.9) 1	-	-	(0.3) 1	(0.4) 2
Alcohol and Other Drug Abuse, Dependence and Psychoses. 291, 292, 293, 303, 304, 305.	-	-	(2.4) 2	(11.4) 41	(8.4) 43
Special Symptons: e.g. tics, stuttering, psychaligia, anorexia nervosa. 307.	(5.7) 2	(18.9) 7	(12.2) 10	(6.9) 25	(8.6) 44
Acute Reaction to Stress Adjustment Reaction. 308, 309.	-	-	(15.9) 13	(14.4) 52	(12.6) 65
Organic Psychotic Conditions, Non-Psychotic Disorders following Brain Damage. 294, 310.	-	-	(3.7) 4	(1.1) 4	(1.4) 7
Sexual Deviations and Disorders. 302.	-	-	-	-	-
Physiological Malfunction from Mental Factors, Psychic Factors Associated with Diseases elsewhere Classified. 306, 316.	(2.9) 1	-	(3.7) 3	(2.5) 9	(2.5) 13
Depressive Disorder. 311.	-	-	(6.1) 5	(11.7) 42	(9.1) 47
Conduct Disorder. 312.	(11.4) 4	(10.8) 4	(1.2) 1	(1.9) 7	(3.1) 16
Disturbance of Emotions Specific to Childhood and Adolescence. 313.	-	-	(3.7) 3	(0.6) 2	(1.0) 5
Hyperkinesis. 314.	(5.7) 2	(2.7) 1	(1.2) 1	-	(0.8) 4
Developmental Delays. 315.	(8.5) 3	-	(1.2) 1	(0.3) 1	(1.0) 5
Mental Retardation. 317, 318, 319.	(51.4) 18	(48.6) 18	(6.1) 5	(3.3) 12	(10.3) 53
Personality Disorder. 301.	-	(2.7) 1	(6.1) 5	(10.0) 36	(8.2) 42
TOTAL	(100.0) 35	(99.9) 37	(100.0) 82	(99.9) 360	(100.2) 514

Table 24 (cont.)

	TOTAL				
DIAGNOSIS	0 - 4	5 - 9	10 - 14	15 - 19	0 - 19
Neurotic Disorders. 300.	(1.5) 3	(3.6) 7	(16.5) 40	(17.9) 113	(12.7) 163
Psychoses (schizophrenia, affective psychoses and paranoid states). 295, 296, 297.	(0.5) 1	-	(0.4) 2	(9.5) 61	(4.9) 63
Other Non-Organic Psychoses. 298.	(0.5) 1	(0.5) 1	(0.8) 2	(2.5) 16	(1.6) 20
Childhood Psychoses. 299.	(1.0) 2	(1.5) 3	(0.8) 2	(0.2) 1	(0.6) 8
Alcohol and Other Drug Abuse, Dependence and Psychoses. 291, 292, 293, 303, 304, 305.	-	(0.5) 1	(2.1) 5	(10.9) 70	(5.9) 76
Special Symptons: e.g. tics, stuttering, psychaligia, anorexia nervosa. 307.	(3.9) 8	(17.5) 34	(14.5) 35	(5.6) 36	(8.8) 113
Acute Reaction to Stress Adjustment Reaction. 308, 309.	-	(1.0) 2	(13.6) 33	(15.6) 100	(10.5) 135
Organic Psychotic Conditions, Non-Psychotic Disorders following Brain Damage. 294, 310.	-	-	(1.2) 3	(1.2) 8	(0.9) 11
Sexual Deviations and Disorders. 302.	-	-	-	(0.3) 2	(0.2) 2
Physiological Malfunction from Mental Factors, Psychic Factors Associated with Diseases elsewhere Classified. 306, 316.	(4.4) 9	(1.5) 3	(4.1) 10	(1.4) 9	(2.4) 31
Depressive Disorder. 311.	-	(0.5) 1	(2.9) 7	(7.9) 51	(4.6) 59
Conduct Disorder. 312.	(10.7) 22	(16.0) 31	(15.7) 38	(8.6) 55	(11.4) 146
Disturbance of Emotions Specific to Childhood and Adolescence. 313.	-	(1.0) 2	(2.9) 7	(0.5) 3	(0.9) 12
Hyperkinesis. 314.	(2.9) 6	(5.7) 11	(1.7) 4	(0.2) 1	(1.7) 22
Developmental Delays. 315.	(44.4) 91	(23.7) 46	(5.8) 14	(0.5) 3	(12.0) 154
Mental Retardation. 317, 318, 319.	(29.8) 61	(26.3) 51	(14.0) 34	(5.8) 37	(14.3) 183
Personality Disorder. 301.	(0.5) 1	(0.5) 1	(2.9) 7	(11.8) 76	(6.5) 85
TOTAL	(100.1) 205	(99.8) 194	(99.9) 242	(100.1) 642	(100.0) 1283

Table 25 describes the "area and degree of impairment for psychiatric inpatient admissions" for 1981, for the 0-19 age group, for four psychiatric hospitals. (The Izaak Walton Killam Hospital is omitted because it does not use the "psychiatric admission" form used by psychiatric hospitals so that its data are not in the same categories.) More than one of the items may be and is checked off for most patients. Not surprisingly, since these are psychiatric admissions, some 78 percent of patients suffer from intrapsychic function impairment and 98 percent from impairment of behaviour. More than half of the patients have impaired function in the area of school performance and 34 percent in work performance.

Table 26 gives us the "family history of psychiatric disorders by age group, for four psychiatric inpatient hospitals, for 1981". Potentially, the table should help us to answer the question of whether psychiatric disorders tend to cluster in families. An affirmative answer here would have obvious policy implications, since it would mean that preventive efforts should be concentrated on particular families. Unfortunately, the large proportion of "unknowns" (31.9 percent) renders the data at best suggestive. If the unknowns are removed from the total the percentage of inpatients with family history of psychiatric disorder rises to 34 percent. It would appear that either this item should not appear on the form or else that staff should be trained to collect the necessary data in a systematic manner. Should the 34 percent figure actually be accurate then the Secretariat Staff should consider additional research into the question of the extent to which, in Nova Scotia, preventive resources should be focused on families which already have one mental patient.

Table 27 shows the substantial differences in average length of stay of 0-19 age group psychiatric inpatients at five hospitals. Once again, we see that the I.W.K. and Nova Scotia hospitals account for most of the 0-19 age group of psychiatric inpatients. The difference in role between the Nova Scotia and I.W.K. hospitals is also apparent, with the former being a longer term and the latter a shorter term institution. It is

TABLE 25 AREA AND DEGREE OF IMPAIRMENT FOR PSYCHIATRIC INPATIENT ADMISSIONS OF THE 0-19 AGE GROUP, FOR FOUR HOSPITALS, 1981.[1]

AREA OF IMPAIRMENT	1. None	2. Mild	3. Moderate	4. Severe	5. Total
CAPE BRETON HOSPITAL					
Intrapsychic Function	-	-	(96.3) 26	(3.7) 1	(100.0) 27
Behaviour	-	-	(100.0) 27	-	(100.0) 27
Social Relations	-	-	(100.0) 27	-	(100.0) 27
School Performance	(100.0) 27	-	-	-	(100.0) 27
Work Performace	(100.0) 27	-	-	-	(100.0) 27
Physical Function	(100.0) 27	-	-	-	(100.0) 27
Intellectual Development	(100.0) 27	-	-	-	(100.0) 27
ABBIE J. LANE					
Intrapsychic Function	-	-	(42.9) 3	(57.1) 4	(100.0) 7
Behavior	-	-	(14.3) 1	(85.7) 6	(100.0) 7
Social Relations	-	-	(28.6) 2	(71.4) 5	(100.0) 7
School Performance	(42.9) 3	(42.9) 3	-	(14.3) 1	(100.0) 7
Work Performance	(14.3) 1	-	(28.6) 2	(57.1) 4	(100.0) 7
Physical Function	(42.9) 3	(42.9) 3	(14.3) 1	-	(100.0) 7
Intellectual Development	(100.0) 7	-	-	-	(100.0) 7

TABLE 25 (Con't)

AREA OF IMPAIRMENT	1. None	2. Mild	3. Moderate	4. Severe	5. Total
NOVA SCOTIA HOSPITAL					
Intrapsychic Function	(14.4) 35	(35.8) 87	(40.7) 99	(9.1) 22	(100.0) 243
Behaviour	(2.1) 5	(16.0) 39	(65.0) 158	(16.9) 41	(100.0) 243
Social Relations	(11.1) 27	(33.3) 81	(49.4) 120	(6.2) 15	(100.0) 243
School Performance	(42.4) 103	(30.9) 75	(22.2) 54	(4.5) 11	(100.0) 243
Work Performace	(65.4) 159	(17.7) 43	(13.6) 33	(3.3) 8	(100.0) 243
Physical Function	(83.1) 202	(14.0) 34	(2.9) 7	-	(100.0) 243
Intellectual Development	(81.1) 197	(14.0) 34	(2.9) 7	(2.1) 5	(100.1) 243
KINGS COUNTY REHABILITATION					
Intrapsychic Function	-	(37.5) 3	(60.0) 4	(2.5) 1	(100.0) 8
Behavior	-	-	(87.5) 7	(12.5) 1	(100.0) 8
Social Relations	-	-	(62.5) 5	(37.5) 3	(100.0) 8
School Performance	(100.0) 8	-	-	-	(100.0) 8
Work Performance	-	(25.0) 2	(62.5) 5	(12.5) 1	(100.0) 8
Physical Function	(75.0) 6	(25.0) 1	-	1	(100.0) 8
Intellectual	(62.5)	(25.0)	(12.5)		(100.0)

TABLE 25 (Con't)

	ROW TOTALS				
AREA OF IMPAIRMENT	1. None	2. Mild	3. Moderate	4. Severe	5. Total
Intrapsychic Function	(12.3) 35	(31.6) 90	(46.3) 132	(9.8) 28	(100.0) 285
Behaviour	(1.8) 5	(13.7) 39	(67.7) 193	(16.8) 43	(100.0) 285
Social Relations	(9.5) 27	(28.4) 61	(54.0) 154	(8.1) 23	(100.0) 285
School Performance	(49.5) 141	(27.4) 78	(18.9) 54	(4.2) 12	(100.0) 285
Work Performace	(65.6) 187	(15.8) 45	(14.0) 40	(4.6) 13	(100.0) 285
Physical Function	(83.5) 283	(13.3) 38	(2.8) 8	(0.4) 1	(100.0) 285
Intellectual Development	(82.8) 236	(12.6) 36	(2.8) 8	(1.8) 5	(100.0) 285

1. Figures in parenthesis are row percentages.

TABLE 26

FAMILY HISTORY OF PSYCHIATRIC DISORDERS BY AGE GROUP, FOR FOUR PSYCHIATRIC INPATIENT HOSPITAL, 1981.[1]

FAMILY HISTORY OF PSYCHIATRIC DISORDERS	Cape Breton Hospital			Abbie J. Lane			Kings County Rehabilitation			Nova Scotia Hospital			ROW TOTAL		
	0 - 14	15 - 19	0 - 19	0 - 14	15 - 19	0 - 19	0 - 14	15 - 19	0 - 19	0 - 14	15 - 19	0 - 19	0 - 14	15 - 19	0 - 19
1. Yes		(50.0) 13	(48.1) 13		(16.7) 1	(14.3) 1		(25.0) 2	(25.0) 2	(18.8) 9	(21.0) 41	(20.6) 50	(18.0) 9	(24.3) 57	(23.2) 66
2. No	(100.0) 1	(34.6) 9	(37.0) 10		(16.7) 1	(14.3) 1		(25.0) 2	(25.0) 2	(64.6) 31	(43.1) 84	(47.3) 115	(64.0) 32	(40.9) 96	(44.9) 128
3. Unknown		(15.4) 4	(14.8) 4	(100.0) 1	(66.7) 4	(71.4) 5		(50.0) 4	(50.0) 4	(16.7) 8	(35.9) 70	(32.1) 78	(18.0) 9	(34.9) 82	(31.9) 91
Total	(100.0) 1	(100.0) 26	(99.9) 27	(100.0) 1	(100.1) 6	(100.0) 7		(100.0) 8	(100.0) 8	(100.1) 48	(100.0) 195	(100.0) 243	(100.0) 50	(100.1) 235	(100.0) 285

1. Numbers in brackets are percentages of column totals.

TABLE 27: LENGTH OF STAY FOR PSYCHIATRIC INPATIENTS, BY AGE GROUP, FOR FIVE HOSPITALS, 1981.[1]

	Cape Breton Hospital			Abbie J. Lane			Kings Co. Rehab.			N.S. Hospital			I.W.K. Hospital		
	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19	0 - 9	10 - 19	0 - 19
# of days	22	229	251	16	424	440	-	278	278	1,841	18,253	20,094	3,663	3,502	7,165
# of separations	1	26	27	1	6	7	-	7	7	12	234	246	312	179	491
Average Length of Stay	22.0	8.8	9.3	16.0	70.7	62.9	-	39.7	39.7	153.4	78.0	81.7	11.7	19.6	14.6

1. Average length of stay refers to number of days.

Table 27 (cont.)

	ROW TOTAL		
	0 - 9	10 - 19	0 - 19
# of Days	5542	22,686	28,228
# of Separations	326	452	778
Average Length of Stay	17.0	50.2	36.3

interesting to note that, while for the I.W.K. Hospital there is little difference in average length of stay for the 0-9 age group as compared to the 10-19 group, for the Nova Scotia Hospital the young age group stays almost twice as long on average as the older group.

Table 28 describes the number of treatment services by age group for each of four Nova Scotia psychiatric hospitals in 1981. It was necessary to treat the 0-14 age group as a single category because there would otherwise be too few cases in each cell to permit interpretation. Up to three services per patient may be recorded, so that a number in brackets represents not the percentage of 15-19 year olds who received treatment but rather the percentage of all treatment services which were provided for that age group. Clearly, many patients received more than one treatment. The data for Cape Breton Hospital are somewhat misleading since it generally keeps patients in this age group for brief periods only until it is possible to transfer them elsewhere.

Looking at the row totals, it is apparent that chemotherapy was the single most frequent type of therapy (excluding "other"), followed by individual therapy and group therapy.

Combined Inpatient and Outpatient Statistics

Table 29 combines table 24's inpatient with table 23's outpatient diagnostic data. It is important to realize that there is some overlap between inpatients and outpatients — these two categories are definitely not mutually exclusive. Unfortunately, the Department of Health's computer system does not at present have the capacity to exclude readily or identify those who are in both categories. The figures in table 29 must therefore be taken only as approximations. It should also be noted that this table excludes patients seen by family physicians (who are, however, discussed subsequently).

Since there are so many more outpatients than inpatients, table 29

TABLE 28

TREATMENT SERVICES BY AGE GROUP FOR EACH PSYCHIATRIC INPATIENT HOSPITAL, 1981

	FACILITY											
	Cape Breton Hospital			Abbie J. Lane			Kings County Rehab.			Nova Scotia Hospital		
TREATMENT SERVICES	0-14	15-19	0-19	0-14	15-19	0-19	0-14	15-19	0-19	0-14	15-19	0-19
1. Investigation Only	-	(3.8) 1	(3.7) 1	-	-	-	-	-	-	(3.5) 3	(10.5) 42	(9.3) 45
2. Individual Therapy	-	-	-	(50.0) 1	(35.3) 6	(36.8) 7	-	(21.7) 5	(21.7) 5	(12.9) 11	(18.8) 75	(17.7) 86
3. Group Therapy	-	-	-	-	(11.8) 2	(10.5) 2	-	(26.1) 6	(26.1) 6	(10.6) 9	(11.5) 46	(11.3) 55
4. Family Therapy	-	-	-	-	(5.9) 1	(5.3) 1	-	(4.3) 1	(4.3) 1	(5.9) 5	(1.0) 4	(1.9) 9
5. Behavior Therapy	-	-	-	-	(11.8) 2	(10.5) 2	-	(4.3) 1	(4.3) 1	(21.2) 18	(3.5) 14	(6.6) 32
6. Chemotherapy	(100.0) 1	(96.2) 25	(96.3) 26	(50.0) 1	(35.3) 6	(36.8) 7	-	(26.1) 6	(26.1) 6	(8.2) 7	(20.3) 81	(18.1) 88
7. E.C.T.	-	-	-	-	-	-	-	-	-	-	(1.3) 5	(1.0) 5
8. Subcoma Insulin	-	-	-	-	-	-	-	-	-	-	-	-
9. Other	-	-	-	-	-	-	-	(17.4) 4	(17.4) 4	(37.6) 32	(33.3) 133	(34.0) 165
Total	(100.0) 1	(100.0) 26	(100.0) 27	(100.0) 2	(100.1) 17	(99.9) 19		(99.9) 23	(99.9) 23	(99.9) 85	(100.2) 400	(99.9) 485

TABLE 28

TREATMENT SERVICES BY AGE GROUP FOR EACH PSYCHIATRIC INPATIENT HOSPITAL, 1981

	ROW TOTALS		
TREATMENT SERVICES	0-14	15-19	0-19
1. Investigation Only	(3.4) 3	(9.2) 43	(8.3) 46
2. Individual Therapy	(13.6) 12	(18.5) 86	(17.7) 98
3. Group Therapy	(10.2) 9	(11.6) 54	(11.4) 63
4. Family Therapy	(5.7) 5	(1.3) 6	(2.0) 11
5. Behavior Therapy	(20.5) 18	(3.6) 17	(6.3) 35
6. Chemotherapy	(10.2) 9	(25.3) 118	(22.9) 127
7. E.C.T.	-	(1.1) 5	(0.9) 5
8. Subcoma Insulin	-	-	-
9. Other	(36.4) 32	(29.4) 137	(30.5) 169
Total	(100.0) 88	(100.0) 466	(100.0) 554

TABLE 29: All Psychiatric Diagnoses by Percentage and per Thousand Population, by Age Group for Nova Scotia, 1981.[1, 2]

DIAGNOSIS	0 - 4		5 - 9		10 - 14		15 - 19		0 - 19	
	(Percentage)[3] Number	Per Thousand Rate	(Percentage) Number	Per Thousand Rate	(Percentage) Number	Per Thousand Rate	(Percentage) Number	Per Thousand Rate	(Percentage) Number	Per Thousand Rate
leurotic Disorders 300	(2.1) 8	0.13	(4.1) 33	0.50	(10.2) 111	1.54	(13.7) 216	2.52	(9.6) 368	1.29
'sychoses (schizophrenia, ıffective psychoses, ›aranoid states) 295, '96, 297	(0.3) 1	0.02	(0.1) 1	0.02	(0.3) 3	0.04	(7.1) 111	1.29	(3.0) 116	0.41
›ther Non-Organic 'sychoses 298	(0.3) 1	0.02	(0.1) 1	0.02	(0.2) 2	0.03	(1.3) 20	0.23	(0.6) 24	0.08
:hildhood Psychoses '99	(1.6) 6	0.10	(0.9) 7	0.11	(0.3) 3	0.04	(0.1) 2	0.02	(0.5) 18	0.06
ılcohol & other Drug ıbuse, Dependence & 'sychoses 291, 292, 293 ›03, 304, 305	(0.3) 1	0.02	(0.1) 1	0.02	(1.4) 15	0.21	(5.7) 90	1.05	(2.8) 107	0.38
›pecial Symptoms: tics, ›tuttering, psychalgia, ›norexia nervosa 307	(4.0) 15	0.25	(6.6) 53	0.80	(5.6) 61	0.85	(2.8) 44	0.51	(4.5) 173	0.61
ıcute Reaction to ›tress. Adjustment ›eaction. 308, 309	(21.8) 82	1.35	(36.4) 291	4.41	(36.9) 403	5.60	(31.3) 492	5.74	(33.0) 1268	4.46

Table 29 (cont.)

DIAGNOSIS	0 - 4		5 - 9		10 - 14		15 - 19		0 - 19	
	(Percentage)[3] Number	Per Thousand Rate	(Percentage) Number	Per Thousand Rate	(Percentage) Number	Per Thousand Rate	(Percentage) Number	Per Thousand Rate	(Percentage) Number	Per Thousand Rat
Organic psychotic conditions. Non-psychotic disorders following brain damage. 294, 310	-	-	-		(0.6) 7	0.10	(0.8) 13	0.15	(0.5) 20	0.07
Sexual Deviations and Disorders. 302	-	-	-		(0.1) 1	0.01	(0.6) 9	0.10	(0.3) 10	0.04
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified 306, 316	(2.4) 9	0.15	(0.9) 7	0.11	(1.3) 14	0.19	(0.8) 12	0.14	(1.1) 42	0.15
Depressive Disorder, 311	(0.3) 1	0.02	(0.3) 2	0.03	(1.5) 16	0.22	(5.1) 80	0.93	(2.6) 99	0.35
Conduct Disorder, 312	(12.2) 46	0.76	(17.8) 142	2.15	(21.9) 239	3.32	(11.4) 179	2.09	(15.8) 606	2.13
Disturbance of emotions specific to childhood and adolescence 313	(1.6) 6	0.10	(3.9) 31	0.47	(4.3) 47	0.65	(1.2) 19	0.22	(2.7) 103	0.36
Hyperkinesis 314	(5.3) 20	0.33	(4.8) 38	0.58	(1.8) 20	0.28	(0.1) 2	0.02	(2.1) 80	0.28

Table 29 (cont.)

DIAGNOSIS	0 - 4 (Percentage)[3] Number	0 - 4 Per Thousand Rate	5 - 9 (Percentage) Number	5 - 9 Per Thousand Rate	10 - 14 (Percentage) Number	10 - 14 Per Thousand Rate	15 - 19 (Percentage) Number	15 - 19 Per Thousand Rate	0 - 19 (Percentage) Number	0 - 19 Per Thousand Ra
Developmental Delays 315	(29.7) 112	1.85	(14.1) 113	1.71	(6.7) 73	1.01	(1.7) 26	0.30	(8.4) 324	1.14
Mental Retardation 317, 318, 319	(17.5) 66	1.09	(9.8) 78	1.18	(5.0) 55	0.76	(4.4) 70	0.82	(7.0) 269	0.95
Personality Disorder 301	(0.8) 3	0.05	(0.3) 2	0.03	(2.0) 22	0.31	(12.0) 189	2.20	(5.6) 216	0.76
Total	(100.2) 377	6.23	(100.2) 800	12.11	(100.1) 1092	15.18	(100.1) 1574	18.36	(100.1) 3843	13.52

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1. This table includes both in and outpatients. Number of diagnoses for each category were obtained from inpatient admission or outpatient registration forms.

2. Population figures, provided by Statistics Canada, are from the 1981 Census.

3. Numbers in brackets are percentages of column totals.

is in many ways similar to its outpatient equivalent (table 23). Much of the discussion of that earlier table is equally relevant here (e.g., that "reaction to stress" and "adjustment reaction" are probably somewhat inflated).

Unlike its predecessors, table 29 provides not only relative percentages but also number of diagnoses per thousand of population within each respective age group. Thus, looking (for example) at neurotic disorders, we see that for every 1000 children age four or under in Nova Scotia there were .13 diagnoses of "neurotic" and these represented 2.1 percent of all 377 mental disorder diagnoses made for this age group. For the 0-4 group as a whole, there were 6.23 mental disorder diagnoses made (at either an in-patient or outpatient facility) for every thousand children. But for the 5-9 age group, that figure almost doubles, to 12.11 diagnoses. Presumably, this sharp increase reflects both problems associated with being in school and previously undiagnosed conditions which are made more salient by the child's arrival at school. If the latter interpretation is accurate, then a large proportion of mental disorders are not being diagnosed (at least, not at a mental health facility before school age. This possibility suggests that either family physicians and community health nurses are not seeing such children or that they are failing to diagnose them accurately (as was discussed previously).

In at least one case we can be quite confident that misdiagnosis is the problem. Wing et al. (1976) found the prevalence of early childhood autism in children under 15 years of age to vary between .4 and .5 cases per thousand children. Table 29 finds "childhood psychoses" (which would include autism" to have a rate of .06 per thousand for the entire 0-19 age group, and for no age category to have a rate higher than .11. Though table 29 deals with number of diagnoses but not with prevalence, in the case of autism — an illness requiring long-term, on-going treatment — diagnoses and prevalence should be fairly closely related. In the opinion of one advisor to this Study, many of the "missing autism" cases may have been misdiagnosed by family physicians and community health nurses as "mental retardation". Thus, the previous recommendation that mental health staff be given standardized training in pediatric psychiatric diagnosis requires at least one addendum: that training should pay special attention to autism.

And to developmental delay? Of those young children who are being seen at mental health facilities, a substantial proportion (29.7 percent of the 0-4 age group) are being diagnosed as suffering from developmental delay. Here the approriate recommendation must involve not only continuing education in diagnosing developmental delay but also in treating it.

Finally, conduct disorder is a particularly important diagnostic category for the relationship between mental health and social service facilities. While what is cause and what is effect is not clear from the literature, wards of social service agencies frequently suffer from conduct disorders. If mental health facilities (the Youth Health Centres) are to cooperate closely with social service facilities then the former's staff must include considerable expertise in the management of young people suffering from conduct disorder — a diagnosis which in 1981 was made at the rate of 2.13 times for every one thousand 0-19 year olds in Nova Scotia.

Table 30 gives us the percentage of each age group treated at an inpatient or outpatient mental health facility in Nova Scotia in 1981. Table 31 combines inpatients and outpatients in order to give us the absolute number and rate per thousand at which young Nova Scotians are utilizing mental health facilities. In both cases, the figures are only approximate because there is undoubtedly some degree of overlap between inpatients and outpatients. Note that the per thousand rates in table 31 are higher than those provided in table 29. This is because the former table takes its outpatient registration statistics from table 9, which broke down the data by facility rather than by county of residence. Some facilities have a proportion of their patients/clients coming from outside the Province, so that table 31 may slightly exaggerate the rate at which young Nova Scotians are using mental health facilities.

TABLE 30 PROPORTION OF NOVA SCOTIA POPULATION TREATED AT MENTAL HEALTH FACILITIES IN 1981 [1]

Age Group	Number of Patients[2]	Population	Percentage Treated
0-4	341	60,525	0.6%
5-9	888	66,035	1.3%
10-14	1,165	71,930	1.6%
15-19	1,419	85,750	1.7%
0-19	3,813	284,240	1.3%
20+	7,939	563,200	1.4%
Total	11,752	847,440	1.4%

1. 1981 Population figures were supplied by Statistics Canada.

2. This table includes outpatients treated at mental health clinics, inpatients admitted to psychiatric hospitals, and inpatients with psychiatric diagnoses admitted to the I.W.K. It does not include any patients with residence outside of Nova Scotia, or those treated by general practitioners and private psychiatrists.

TABLE 11: TOTAL NOVA SCOTIA INPATIENTS AND OUTPATIENTS BY AGE GROUPS AND SEX, 1981[1]

Age Group	Number of Inpatients[2]			Number of Outpatients[3]			Inpatient and Out-patients Combined			Per Thousand Rates		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
0 - 4	80	43	123	148	93	241	288	136	364	7.4	4.6	6.0
5 - 9	85	45	130	619	299	918	704	344	1048	10.7	10.7	15.9
10 - 14	70	68	138	798	475	1273	868	543	1411	23.5	15.5	19.6
15 - 19	178	106	284	691	732	1423	869	838	1707	19.8	20.1	19.9
0 - 19	413	262	675	2256	1599	3855	2669	1861	4530	18.3	13.4	15.9

1. There is some overlap between inpatients and outpatients.

2. Inpatients are counted by the number of psychiatric separations at the five inpatient hospitals.

3. Number of outpatients is taken from "Row Totals" of Table 9 where breakdown is by facility, rather than county. Some non-Nova Scotians may therefore have been included.

4. 1981 Census figures were provided by Statistics Canada.

Perhaps the most interesting data in table 31 have to do not with absolute rate but with sex differences. For inpatients and outpatients combined, males utilize mental health facilities with consistently greater frequency than do females, until the 15-19 age group. At that point, females overtake males in the use of mental health facilities. This point will be returned to in the next section, when data from private practitioners are discussed. Overall, there were approximately 2669 boys and young men who used Nova Scotia's mental health facilities, in 1981, compared with approximately 1861 girls and young women. If one deducts ten percent from the total of 4530 to account for out-of-province users and for overlap between inpatients and outpatients, in 1981 this Province's mental health facilities will still have served over 4000 young people.

Private Physicians and Their Age 0-19 Mental Disorder Patients

Mental health facilities—clinics and hospitals—are often used as a last resort. Most of us take most of our problems to our own family doctor or, at times, to a private psychiatrist. What kinds of psychiatric diagnoses are these physicians making for our children and adolescents? Tables 32 to 39 utilize data supplied by the Nova Scotia Health Services and Insurance Commission. They combine information for private psychiatrists with that for general practitioners. Since physicians at the Izaak Walton Killam Hospital also bill M.S.I. (Medical Services Insurance) for their services—though their employing hospital and not they themselves receive the payment, in this case—the I.W.K. Hospital practitioners are also included in these tables.

The Health Services Insurance Commission data are collected primarily for billing and not research purposes. That is, each time a Nova Scotia physician treats a patient on a fee-for-service basis (as opposed to as part of his/her salaried employment at a hospital or other facility), he or she bills M.S.I. (Medical Services Insurance). M.S.I.

requires the physician to indicate both service rendered and diagnosis made. The family physician is not ordinarily an expert in the use of the ICD-9 mental disorder categories discussed earlier, however: M.S.I. personnel read the physician's noted diagnosis and "translate" it to ICD-9 codes.

Counties

Earlier, it was found that some counties contributed age 0-19 mental health outpatients at a far higher rate than others, even when population was held constant. Perhaps in those counties with low rates of utilization of mental health facilities, private physicians are filling the need. On the other hand, since private practitioners do occasionally refer patients to mental health facilities, counties with a high rate of M.S.I. mental disorder patients might also have a high utilization rate of mental health outpatient facilities. These two possible trends are not mutually exclusive, however: both tendencies may occur simultanteously.

Table 32 takes the number of age 0-19 mental health outpatients-per-thousand-by-county from table 5 (discussed previously) and compares it to its M.S.I. equivalent (the number of 0-19 I.W.K. Hospital and private mental health patients-per thousand-by-county). The "ratio" column is simply the number of M.S.I. patients divided by the number of mental health facility outpatients. Thus, a large ratio indicates that the number of private mental disorder patients is that many times the number of mental health facility outpatients. M.S.I. data, however, utilize fiscal years (ending in April) while the outpatient data are for calender 1981. Given that there is some delay between the time a physician delivers a service and M.S.I. records his/her billing for that service, the two types of year are sufficiently coincident to permit ready comparison.

Table 32 shows no consistent relationship between M.S.I. mental disorder patients and mental health facility outpatients, however. What

TABLE 32: RATE PER THOUSAND COMPARISON OF AGE 0-19 M.S.I. MENTAL DISORDER PATIENTS VERSUS MENTAL HEALTH OUTPATIENTS, BY COUNTY, 1981.[1,2]

County	M.S.I. Rate Per 1000	Outpatient Rate Per 1000	Ratio[3]
Annapolis	25.4	11.0	2.3
Antigonish	21.9	9.6	2.3
Cape Breton	35.3	4.9	7.2
Colchester	27.8	8.8	3.2
Cumberland	40.4	10.2	4.0
Digby	33.1	8.0	4.1
Guysborough	26.9	11.7	2.3
Halifax	50.3	14.5	3.5
Hants	47.8	8.7	5.5
Inverness	23.5	8.1	2.9
Kings	36.1	15.8	2.3
Lunenburg	48.5	14.5	3.3
Pictou	32.7	11.0	3.0
Queens	31.6	11.2	2.8
Richmond	28.9	10.7	2.7
Shelburne	32.2	8.8	3.7
Victoria	16.5	2.1	7.9
Yarmouth	36.1	11.3	3.2
Total	39.5	11.0	3.6

1. The rate of age 0-19 mental health outpatients-per-thousand-by-county is taken from Table 1123 cr. The M.S.I. (private physicians') data were supplied by the Nova Scotia Health Services and Insurance Commission.

2. Note that both the M.S.I. and outpatient figures include I.W.K.H. patients.

3. The "ratio" equals the M.S.I. rate divided by the outpatients-per-thousand rate.

it does show is that, if we are to accept private physicians' diagnoses at face value, approximately 3.6 times more Nova Scotia mental health patients in the 0-19 age group are being treated by private physicians than by mental health outpatient facilities. The range is from 5.5 times as many (for Hants County) to 2.3 times as many (Annapolis, Antigonish, Guysborough, Kings). (Since I.W.K. Hospital patients appear in both categories, these ratios are approximate.)

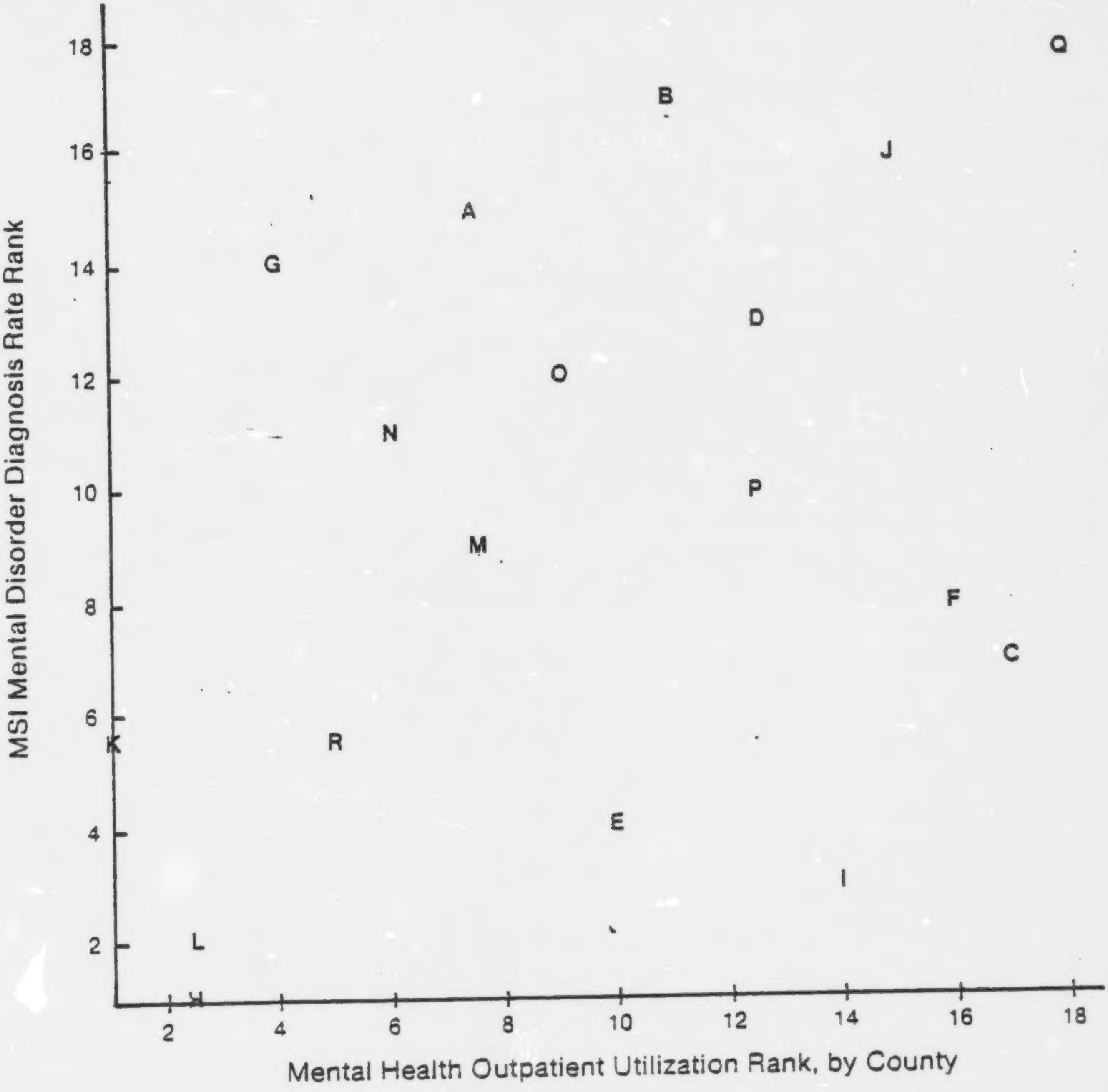
Another way to get at the relationship between utilization of mental health outpatient facilities by the 0-19 group versus this age category's utilization rate of private practice physicians for mental health services is to rank order the counties in terms of these two rates. Figure 5 does so, in the form of a scattergram. A scattergram provides a visual correlation between two variables. In Figure 5, the counties are ranked from highest utilization (equals "one") to lowest utilization rate (equals "eighteen"). The shape of the scattergram indicates little correlation except at the extremes. The three counties with the highest mental health facility utilization rates were Kings, Halifax and Lunenburg; their M.S.I. equivalents were Halifax, Lunenburg and Hants. Thus, Halifax and Lunenburg counties enjoy both high rates of utilization of mental health outpatient facilities and also high rates of private physician treatment of mental disorder, for the 0-19 age group.

At the other extreme, Victoria, Cape Breton and Digby counties have the lowest rates of mental health outpatient facility utilization. Their M.S.I. equivalents are Victoria, Antigonish and Inverness counties. Victoria County, therefore, has at once the lowest mental health outpatient utilization rate and the lowest rate of private physician treatment of mental disorders. It is fair to say that if Victoria County children and adolescents are being treated for mental disorders then it is not by Nova Scotia's health care system.

Adolescent Sex Differences in Utilization

Table 33 provides the actual number of age 0-19 I.W.K. Hospital and

Figure 5. Scattergram comparison of county rank for age 0-19 outpatient mental health facility utilization rates vs. MSI mental disorder diagnosis rates.[1]



(Key to Counties: A-Annapolis, B-Antigonish, C-Cape Breton, D-Colchester, E-Cumberland, F-Digby, G-Guysborough, H-Halifax, I-Hants, J-Inverness, K-Kings, L-Lunenburg, M-Pictou, N-Queens, O-Richmond, P-Shelburne, Q-Victoria, R-Yarmouth

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[1] Outpatient rankings are based on table 5. MSI data were supplied by the Nova Scotia Health Services and Insurance Commission. Low rank indicates high utilization rate per thousand 0-19 age population.

TABLE 33: NUMBER OF AGE 0 - 19 M.S.I. MENTAL DISORDER PATIENTS (CATEGORIES 291-319) FOR FISCAL 1981, BY AGE AND SEX CATEGORY, FOR EACH COUNTY.[1, 2]

COUNTY	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Annapolis	(5.4) 10	(3.3) 6	(8.7) 16	(10.3) 19	(1.6) 3	(12.0) 23	(10.9) 20	(8.2) 15	(19.0) 35	(18.5) 34	(41.8) 77	(60.3) 111	(45.1) 83	(54.9) 101	(100.0) 184
Antigonish	(5.6) 9	(1.9) 3	(7.5) 12	(5.6) 9	(6.3) 10	(11.9) 19	(10.0) 16	(10.6) 17	(20.6) 33	(13.1) 21	(46.9) 75	(60.0) 96	(34.4) 55	(65.6) 105	(100.0) 160
Cape Breton	(6.4) 102	(4.0) 65	(10.4) 167	(6.6) 106	(4.0) 65	(10.6) 171	(8.8) 141	(6.3) 101	(15.1) 242	(17.1) 274	(46.8) 725	(63.9) 1026	(38.8) 623	(61.2) 983	(100.0) 1606
Colchester	(5.5) 22	(6.0) 24	(11.5) 46	(8.5) 34	(5.5) 22	(14.0) 56	(8.5) 43	(8.3) 33	(16.8) 67	(16.3) 65	(41.4) 165	(57.6) 230	(38.8) 155	(61.2) 244	(100.0) 399
Cumberland	(4.9) 22	(4.2) 19	(9.1) 41	(10.0) 45	(4.9) 22	(14.8) 67	(10.8) 49	(10.0) 45	(20.8) 94	(15.9) 72	(39.4) 178	(55.3) 250	(41.6) 108	(58.4) 264	(100.0) 452
Digby	(6.8) 16	(5.1) 12	(11.8) 28	(8.9) 21	(3.8) 9	(12.7) 30	(8.9) 21	(9.3) 22	(18.1) 43	(17.7) 42	(39.7) 94	(57.4) 136	(42.2) 100	(57.8) 137	(100.0) 237
Guysborough	(4.8) 6	(5.6) 7	(10.3) 13	(3.2) 4	(6.3) 8	(9.5) 12	(7.9) 10	(7.9) 10	(15.9) 20	(15.9) 20	(48.4) 61	(64.3) 81	(31.7) 40	(68.3) 86	(100.0) 126
Halifax	(8.8) 408	(6.3) 292	(15.1) 700	(9.6) 445	(5.6) 258	(15.1) 703	(8.9) 414	(8.3) 387	(17.3) 801	(14.8) 688	(37.7) 1750	(52.5) 2438	(42.1) 1955	(57.9) 2687	(100.0) 4642
Hants	(7.1) 40	(4.6) 26	(11.8) 66	(9.8) 55	(2.9) 16	(12.7) 71	(8.0) 45	(8.4) 47	(16.4) 92	(14.6) 82	(44.6) 250	(59.2) 332	(39.6) 222	(60.4) 399	(100.0) 561

TABLE 33 (cont.)

COUNTY	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Inverness	(8.1) 16	(2.5) 5	(10.7) 21	(7.6) 15	(4.1) 8	(11.7) 23	(9.6) 19	(9.1) 18	(18.8) 37	(17.3) 34	(41.6) 82	(58.9) 116	(42.6) 84	(57.4) 113	(100.0) 197
Kings	(4.8) 29	(4.8) 29	(9.6) 58	(7.2) 44	(4.3) 26	(11.5) 70	(11.2) 68	(11.0) 67	(22.2) 135	(15.0) 91	(41.7) 253	(56.7) 344	(38.2) 232	(61.8) 375	(100.0) 607
Lunenburg	(7.0) 47	(5.0) 34	(12.0) 81	(10.8) 73	(7.4) 50	(18.2) 123	(8.6) 58	(8.0) 54	(16.6) 112	(14.1) 95	(39.1) 264	(53.2) 359	(40.4) 273	(59.6) 402	(100.0) 675
Pictou	(9.1) 52	(6.0) 34	(15.1) 86	(8.1) 46	(5.8) 33	(13.9) 79	(8.4) 48	(6.8) 39	(15.3) 87	(15.1) 86	(40.7) 232	(55.8) 318	(40.7) 232	(59.3) 338	(100.0) 570
Queens	(7.7) 10	(4.6) 6	(12.3) 16	(10.0) 13	(10.0) 13	(20.0) 26	(13.1) 17	(11.5) 15	(24.6) 32	(16.9) 22	(26.2) 34	(43.1) 56	(47.7) 62	(52.3) 68	(100.0) 130
Richmond	(2.2) 3	(2.2) 3	(4.4) 6	(6.7) 9	(4.4) 6	(11.1) 15	(8.9) 12	(6.7) 9	(15.6) 21	(17.0) 23	(51.9) 70	(68.9) 93	(34.8) 47	(65.2) 88	(100.0) 135
Shelburne	(5.8) 11	(5.8) 11	(11.5) 22	(6.3) 12	(5.8) 11	(12.0) 23	(6.8) 13	(12.6) 24	(19.4) 37	(15.7) 30	(41.4) 79	(57.1) 109	(34.6) 66	(65.4) 125	(100.0) 191
Victoria	(4.2) 2	(2.1) 1	(6.3) 3	(8.3) 4	(14.6) 7	(22.9) 11	(8.3) 4	(4.2) 2	(12.5) 6	(18.8) 9	(39.6) 19	(58.3) 28	(39.6) 19	(60.4) 29	(100.0) 48
Yarmouth	(8.3) 26	(6.7) 21	(15.0) 47	(6.1) 19	(2.9) 9	(8.9) 28	(9.3) 29	(10.9) 34	(20.1) 63	(13.1) 41	(42.8) 134	(55.9) 175	(36.7) 115	(63.3) 198	(100.0) 313

TABLE 33 (cont.)

COUNTY	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Total	(7.4) 831	(5.3) 598	(12.7) 1429	(8.7) 973	(5.1) 576	(13.0) 1549	(9.1) 1018	(8.4) 939	(17.4) 1957	(15.4) 1729	(40.7) 4569	(56.1) 6298	(40.5) 4551	(59.5) 6682	(100.0) 11,233

1. Numbers in brackets are percentages of row totals.
2. M.S.I. mental disorder patients include all private practitioners plus I.W.K.H. patients.

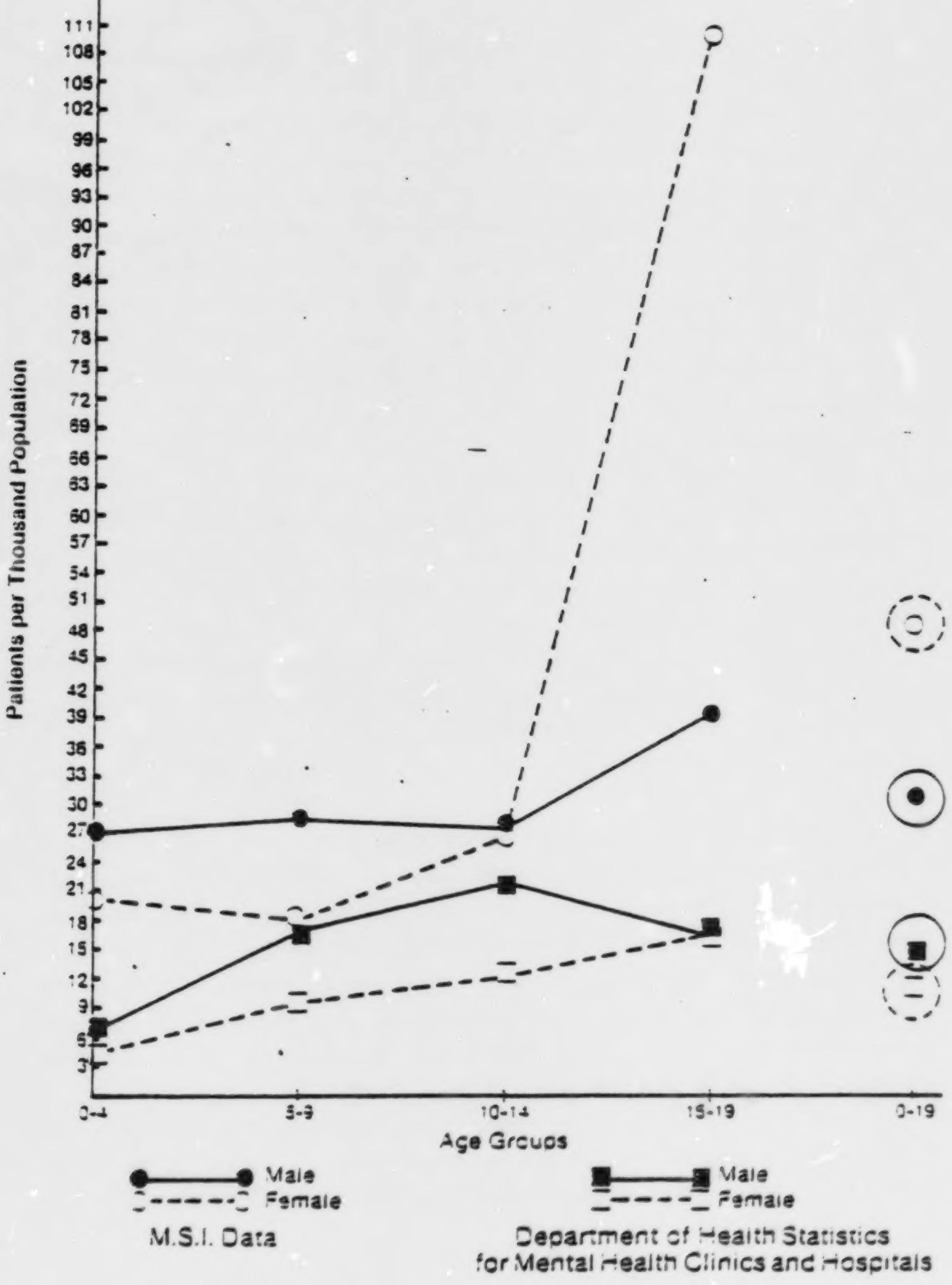
private physicians' mental disorder patients, by county, age and sex, for 1981. Figure 6 provides these data for the Province as a whole but drawn as a line graph on a per thousand population basis and with the equivalent mental health facility data included for comparison purposes. Note that mental health facility inpatients and outpatients are combined. We see that table 32's figure of approximately 3.6 times as many private practitioners' mental disorder patients as mental health facility patients masked some interesting complexities. Through age 14 the two groups do not differ too strikingly. For the 15-19 age group, however, M.S.I. females leap to almost three times the rate of their male age peers, while no such trend occurs for the mental health facility data. What is happening?

That the female 15-19 age group should so dramatically overtake its male counterpart as mental disorder patients of private practitioners is startling but not unusual. Apparently, these adolescent females are simply coming to act as adult women. Mechanic (1978) summarizes numerous studies in pointing out that "women report various symptoms more frequently than men and use medical and psychiatric facilities more commonly" (pp. 252-253). D'Arcy and Schmitz (1979), using 1971 Saskatchewan data, find "that men have slightly higher utilization rates in the public sector...but that women utilize private-sector services at almost twice the rate of men" (pp. 19-20).

Mechanic (1978:253) lists various explanations for sex differences in utilization of psychiatric and general medical facilities, including: sex differences in socialization and cultural expectation, sex differences in threshold reponse to symptoms, actual differences in the frequency of mental disorder, and sex biases in diagnostic judgements. Unfortunately, neither he nor D'Arcy and Schmitz explain why women prefer private practitioners to mental health facilities. Nor would an effort to answer this question be within the scope of this Study.

But it is appropriate to suggest that research into utilization of Nova Scotia's medical and mental health services is likely to have considerable planning and program implications and, in line with the recom-

Figure 6. Number of Age 0-19 Mental Health Facility Patients Compared with MSI Mental Disorder Patients, Per Thousand Population, by Age Group and Sex, Nova Scotia, 1981.[1]



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[1] Based on 1981 census figures provided by Statistics Canada and on Department of Health mental health inpatient and outpatient statistics.

mendations made in chapter 7, should have a high budgetary priority. For example, table 38 (discussed below) finds that a large proportion of age 15-19 Nova Scotia females receiving mental disorder diagnoses from their physicians are placed in the "neurotic" category. Would this also be true for adult women? If so, it is necessary to ask whether the family physician's office is necessarily the best (and most cost-effective) means of treatment for so large a number of "neurotic" women. What are their real problems? Should alternative programs be developed? Without data we cannot even begin to consider appropriate alternative programs.

Why should age 15-19 females so strongly prefer private physicians for treatment rather than the mental health facilities? The fact that the great incease in female utilization of private practitioners does not occur for younger patients suggests that as soon as a young woman is in a position to make her own decision (as opposed to having a parent or social worker choose or not choose the source of treatment for her), she opts for the physician in private practice. Is the issue one of privacy, or perhaps of confidence? The Secretariat Staff must consider, in aiding the establishment of YHCs, whether it would not be wise for them to consider developing specific programs for young women in middle and late adolescence. First, however, additional analysis of M.S.I. data is needed.

Table 34 compares the age 0-19 proportion of mental health patients treated by outpatient and inpatient mental health facilities with those treated by physicians in private practice and by I.W.K.H. physicians. The resulting data are only approximate, for several reasons. The first of these is that, once again, the private practitioners' (M.S.I.) data refer to fiscal rather than calender 1981. Then, as was discussed earlier, there is overlap between the inpatient and outpatient categories. There is additional overlap between private physicians' patients and those utilizing Department of Health facilities — private practice physicians do, after all, make a varying proportion of the referrals received by the latter. Finally, I.W.K. Hospital patients are included in both categories.

TABLE 34: COMPARISON OF PROPORTION OF AGE 0-19 POPULATION TREATED AT MENTAL HEALTH FACILITIES WITH PROPORTION TREATED BY PRIVATE AND I.W.K.H. PRACTITIONERS, 1981 [1,2,3]

Age Group	Population	# Health Facility Patients	%	#M.S.I. Patients	%	centage of Population Treated	Total Per- Per Thousand Population
0 - 4	60,525	341	0.6	1,429	2.4	3.0	29.2
5 - 9	66,035	888	1.3	1,549	2.3	3.9	36.9
10 - 14	71,930	1,165	1.6	1,957	2.7	4.3	43.4
15 - 19	85,750	1,419	1.7	6,298	7.3	9.0	90.0
0 - 19	284,240	3,813	1.3	11,233	4.0	5.3	52.9

1. Mental health facility data includes both inpatients and outpatients for calender 1981. M.S.I. data are for fiscal year 1981.

2. Mental health faciltiy data were supplied by the Department of Health (taken from table 30). Private practitioner (M.S.I.) data include both psychiatrists in private practice and family practitioners. Census data for 1981 were supplied by Statistics Canada.

3. Since there is some overlap between inpatients and outpatients, some overlap between both and patients treated by private practitioners, and since I.W.K. Hospital patients appear in both categories, these figures are somewhat inflated.

Nevertheless, an important point emerges from table 34: even if one deducts 10 percent for overlap from the total number of patients treated, it still appears that nearly one of every twenty children and adolescents in Nova Scotia, in 1981, was treated for a mental disorder of some kind. It would be interesting to see what these figures would be over a five-year period. It is clear that problems in the emotional-behavioural-psychiatric area affect far more young people than one might expect. (Comparable figures for Saskatchewan adults seen for psychiatric reasons in 1971 were 55.7 for adult males and 97.1 for adult females, on a per thousand basis [D'Arcy and Schmitz 1979:19]).

Given that private practitioners (plus the I.W.K. Hospital staff psychiatrists) see several times as many mental disorder patients as do facilities specializing in mental health, one might get the impression that such patients make up a major part of their practice. Table 35 finds that this is not the case, though there is considerable variation from one age group to another. For the age 0-19 group as a whole, mental disorder patients make up 4.6 percent of private practice, with a range of 2.4 percent of the 0-4 group to 8.5 percent for the 15-19 age group. Thus, physicians in private practice (plus I.W.K. Hospital staff) are seeing 3.6 times as many mental health patients as are outpatient facilities specializing in them, even though such patients make up only 4.6 percent of their total age 0-19 caseload! Obviously, even minor changes in the proportion of mental disorder child and adolescent patients seen by private practitioners would have major effects on the Province's mental health facilties.

There is an important difference between proportion of practitioners' patients with mental disorder diagnoses and the proportion of funds paid by M.S.I. for such patients. Table 36 builds on the previous table by studying this distinction. Since a mental disorder diagnosis permits a private practitioner to bill M.S.I. for "psychotherapy", and thus receive a higher payment than would otherwise be the case, one might expect that mental disorder patients tend to be more expensive than others. Table 36 shows that the contrary is true. Overall, the 4.6

TABLE 35: PROPORTION OF PRIVATE PRACTITIONERS' AND I.W.K.H. PATIENTS WITH DIAGNOSED MENTAL DISORDER BY AGE GROUP AND SEX

FOR FISCAL 1981.

	MALE			FEMALE			BOTH		
AGE GROUP	# of mental dis-order patients	Total # of patients	%[2]	# of mental dis-order patients	Total # of patients	%	# of mental dis-order patients	Total # of patients	%
0 - 4	(18.3) 831	(25.5) 30,942	2.7	(8.9) 598	(24.0) 29,484	2.0	(12.7) 1429	(24.7) 60,426	2.4
5 - 9	(21.4) 973	(23.4) 28.330	3.4	(8.6) 576	(21.5) 26,492	2.2	(13.8) 1549	(22.4) 54,822	2.8
10 - 14	(22.4) 1018	(23.1) 27,974	3.6	(14.1) 939	(21.8) 26.834	3.6	(17.4) 1957	(22.4) 54,800	3.6
15 - 19	(38.0) 1729	(28.0) 33,947	5.1	(68.4) 4569	(32.7) 40,196	11.4	(56.1) 6298	(30.4) 74,143	8.5
0 - 19	(100.1) 4551	(100.0) 121,193	3.8	(100.0) 6682	(100.0) 123,006	5.4	(100.0) 11,233	(99.9) 244,199	4.6

1. Numbers in brackets are percentages of column totals.

2. The % column gives the proportion of the total number of patients which is made up by mental disorder patients.

TABLE 36: PERCENTAGE OF PRIVATE PRACTICE PATIENT POPULATION AND TOTAL M.S.I. EXPENDITURE CONTRIBUTED BY MENTAL DISORDER PATIENTS, BY AGE GROUP AND SEX, FOR NOVA SCOTIA, 1981.

	MALE		FEMALE		BOTH	
AGE GROUP	% of mental disorder patients in the patient population	% of total funds which was used for mental disorder	% of mental disorder patients in the patient population	% of total funds which was used for mental disorder	% of mental disorder patients in the patient population	% of total funds which was used for mental disorder
0 - 4	2.7%	0.7%	2.0%	0.5%	2.4%	0.6%
5 - 9	3.4%	2.4%	2.2%	1.3%	2.8%	1.9%
10 - 14	3.6%	3.5%	3.5%	3.0%	3.6%	3.3%
15 - 19	5.1%	4.5%	11.4%	6.2%	8.5%	5.5%
0 - 19	3.8%	2.4%	5.4%	3.1%	4.6%	2.8%

TABLE 36: PERCENTAGE OF PRIVATE PRACTICE PATIENT POPULATION AND TOTAL M.S.I. EXPENDITURE CONTRIBUTED BY MENTAL DISORDER PATIENTS, BY AGE GROUP AND SEX, FOR NOVA SCOTIA, 1981

	MALE		FEMALE		BOTH	
AGE GROUP	% of mental disorder patients in the patient population	% of total funds which was used for mental disorder	% of mental disorder patients in the patient population	% of total funds which was used for mental disorder	% of mental disorder patients in the patient population	% of total funds which was used for mental disorder
0 - 4	2.7%	0.7%	2.0%	0.5%	2.4%	0.6%
5 - 9	3.4%	2.4%	2.2%	1.3%	2.8%	1.9%
10 - 14	3.6%	3.5%	3.5%	3.0%	3.6%	3.3%
15 - 19	5.1%	4.5%	11.4%	6.2%	8.5%	5.5%
0 - 19	3.8%	2.4%	5.4%	3.1%	4.6%	2.8%

percent of age 0-19 mental disorder patients accounted for only 2.8 percent of M.S.I. fee-for-service expenditures. Though the percentage of expenditure is less than the proportion of mental disorder patients for every age group (through age 19), the disparity is most marked for the 0-4 age group. Here we find that while this group accounted for 2.4 percent of the total patients, they accounted for only .6 percent of expenditure. Apparently, it is less expensive to the taxpayer for private practitioners to provide mental health than other medical services.[1]

Table 37 shows the actual sums involved. In 1981, some $578,255.33 was paid to private and I.W.K. Hospital practitioners (or rather, to the I.W.K.H. for its physicians' services) for treatment of age 0-19 children and adolescents for mental disorder category diagnoses.

What were those diagnoses, though? Table 38 analyses them by frequency and age group. For the 0-19 age group as a whole, the three most frequent diagnoses are neurotic disorders, acute reaction to stress/adjustment reaction, and conduct disorders. These are the same "top three" shown in table 23 (if one discounts that table's "other" category) for mental health facility outpatients, though for that group acute reaction to stress/adjustment reaction and not neurotic disorder was the single most common diagnosis. Stronger differences appear when particular age groups are examined more closely, however.

For the 0-4 age group, for example, the three most frequent M.S.I. diagnoses were conduct disorder, special symptoms, and developmental delays (followed very closely by hyperkinesis). The mental health outpatient facilities appear to have seen only acute reaction to stress/

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[1] On the other hand, if a patient sees a family practitioner several times but is diagnosed as having a mental disorder only on the last visit, fees for the prior visits would not be included in the "mental disorder" expenditure total, which may therefore be underestimated.

TABLE 37: AMOUNT AND PERCENTAGE OF TOTAL M.S.I. FUNDS PAID TO PRIVATE PRACTITIONERS ON A FEE FOR SERVICE BASIS FOR MENTAL DISORDER DIAGNOSIS PATIENTS IN FISCAL 1981 BY AGE GROUP AND SEX.

AGE GROUP	MALE			FEMALE			BOTH		
	Funds paid for mental disorders	Total funds paid	%[1]	Funds paid for mental disorders	Total funds paid	%	Funds paid for mental disorders	Total funds paid	%
0 - 4	$26,105.85	$3,794,097.61	0.7	$15,501.31	$3,097,731.86	0.5	$41,607.16	$6,891,829.47	0.6
5 - 9	55,027.12	2,321,128.15	2.4	25,243.87	1,907,871.28	1.3	80,270.99	4,228,999.43	1.9
10 - 14	68,266.85	1,943,509.86	3.5	53,854.05	1,792,469.19	3.0	122,120.90	3,735,979.05	3.3
15 - 19	103,816.14	2,297,566.53	4.5	230,440.14	3,731,555.30	6.2	334,256,28	6,029,121.83	5.5
0 - 19	253,215.96	10,356,302.15	2.4	325,039.37	10,529,627.63	3.1	578,255.33	20,885,929.78	2.8

1. The % column gives the proportion of total expenditure which is contributed by mental disorder expenditure for each age group.

TABLE 38

NUMBER AND PERCENTAGE OF MENTAL DISORDER DIAGNOSES FOR WHICH PRIVATE & I.W.K.H. PRACTITIONER RECEIVED PAYMENT FROM M.S.I. ON A FEE FOR SERVICE BASIS, IN FISCAL 1981, BY AGE, SEX AND DIAGNOSTIC CATEGORY.[1, 2]

DIAGNOSIS	0 - 4 years			5 - 9 years			10 - 14 year			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Neurotic Disorders 300.	(5.5) 49	(6.3) 40	(5.8) 89	(12.2) 138	(17.3) 112	(14.1) 250	(22.7) 280	(34.1) 384	(28.1) 664	(38.9) 840	(51.8) 2894	(48.2) 3734	(24.1) 1307	(42.9) 3430	(35.3) 4737
Psychoses (schizophrenia, affective psychoses and paranoid states) 295, 296, 297.	(0.1) 1	-	(0.1) 1	(0.4) 5	(0.6) 4	(0.5) 9	(0.5) 6	(0.9) 10	(0.7) 16	(3.5) 76	(1.9) 108	(2.4) 184	(1.6) 88	(1.5) 122	(1.6) 210
Other Non-Organic Psychoses 298.	-	(0.5) 3	(0.2) 3	(0.4) 5	(0.3) 2	(0.4) 7	(0.4) 5	(0.2) 2	(0.3) 7	(1.3) 28	(0.4) 25	(0.7) 53	(0.7) 38	(0.4) 32	(0.5) 70
Childhood Psychoses 299.	(0.4) 4	(0.3) 2	(0.4) 6	(0.7) 8	-	(0.5) 8	(0.2) 3	(0.3) 3	(0.3) 6	(0.05) 1	(0.02) 1	(0.03) 2	(0.3) 16	(0.1) 6	(0.2) 22
Alcohol and Other Drug Abuse, Dependence and Psychoses 291, 292, 293, 303, 304, 305.	(0.3) 3	(0.2) 1	(0.3) 4	(0.3) 3	(0.2) 1	(0.2) 4	(1.5) 19	(0.7) 8	(1.1) 27	(7.7) 167	(1.7) 93	(3.4) 260	(3.5) 192	(1.3) 103	(2.2) 295
Special Symptoms: e.g. tics, stuttering, psychaligia, anorexia nervosa, 307.	(15.1) 135	(18.4) 117	(16.4) 252	(12.9) 145	(15.3) 99	(13.7) 244	(11.0) 136	(10.2) 115	(10.6) 251	(9.8) 212	(10.8) 605	(10.5) 817	(11.6) 628	(11.7) 936	(11.7) 1564
Acute Reaction to Stress Adjustment Reaction, 308, 309.	(3.6) 32	(4.3) 27	(3.9) 59	(7.4) 83	(6.9) 45	(7.2) 128	(13.4) 165	(18.2) 205	(15.7) 370	(13.6) 294	(16.7) 933	(15.8) 1227	(10.6) 574	(15.1) 1210	(13.3) 1784

TABLE 38 (cont.)

DIAGNOSIS	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Organic Psychotic Conditions, Non-Psychotic Disorders following Brain Damage. 294, 310.	(0.2) 2	(0.5) 3	(0.3) 5	(0.3) 3	(0.8) 5	(0.5) 8	(0.4) 5	(0.2) 2	(0.3) 7	(0.5) 10	(0.1) 6	(0.2) 16	(0.4) 20	(0.2) 16	(0.3) 36
Sexual Deviations and Disorders. 302.	(0.1) 1	(0.3) 2	(0.2) 3	(0.2) 2	(0.5) 3	(0.3) 5	(0.2) 2	(0.2) 2	(0.2) 4	(0.5) 11	(0.4) 23	(0.4) 34	(0.3) 16	(0.4) 30	(0.3) 46
Physiological Malfunction from Mental Factors, Psychic Factors Associated with Diseases elsewhere Classified. 306, 316.	(0.9) 8	(1.3) 8	(1.0) 16	(0.9) 10	(2.6) 17	(1.5) 27	(1.7) 21	(3.0) 34	(2.3) 55	(1.1) 24	(1.0) 55	(1.0) 79	(1.2) 63	(1.4) 114	(1.3) 177
Depressive Disorder. 311.	(0.1) 1	(0.3) 2	(0.2) 3	(0.8) 9	(2.8) 18	(1.5) 27	(3.0) 37	(2.3) 53	(1.1) 90	(1.0) 171	(1.0) 557	(1.0) 729	(1.2) 218	(1.4) 630	(1.3) 848
Conduct Disorder. 312.	(33.3) 299	(40.7) 259	(36.4) 558	(23.3) 263	(21.7) 141	(22.7) 404	(19.3) 238	(11.3) 127	(15.5) 365	(5.0) 109	(1.5) 83	(2.5) 192	(16.8) 909	(7.6) 610	(11.3) 1519
Disturbance of Emotions Specific to Childhood and Adolescence. 313.	(0.9) 8	(1.6) 10	(1.2) 18	(3.2) 36	(3.9) 25	(3.4) 61	(4.2) 52	(3.5) 39	(3.9) 91	(0.6) 13	(0.6) 32	(0.6) 45	(2.0) 109	(1.3) 106	(1.6) 215
Hyperkinesis. 314.	(18.6) 167	(11.0) 70	(15.5) 237	(13.1) 148	(7.6) 49	(11.1) 197	(6.6) 81	(1.8) 20	(4.3) 101	(0.5) 11	(0.1) 6	(0.2) 17	(7.5) 407	(1.8) 145	(4.1) 552

TABLE 38 (cont.)

DIAGNOSIS	0 - 4 years			5 - 9 years			10 - 14 years			15 - 19 years			0 - 19 years		
	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
Developmental Delays. 315.	(17.8) 160	(12.8) 81	(15.7) 241	(19.3) 217	(14.5) 94	(17.5) 311	(9.5) 117	(6.2) 70	(7.9) 187	(1.7) 37	(0.2) 9	(0.6) 46	(9.8) 531	(3.2) 254	(5.9) 785
Mental Retardation. 317, 318, 319.	(2.7) 24	(1.6) 10	(2.2) 34	(3.5) 40	(4.3) 28	(3.8) 68	(3.4) 42	(2.7) 30	(3.1) 72	(.7) 36	(0.5) 30	(0.9) 66	(2.6) 142	(1.2) 98	(1.8) 240
Personality Disorder. 301.	(0.3) 3	-	(0.2) 3	(1.1) 12	(0.9) 6	(1.0) 18	(1.9) 24	(2.0) 22	(1.9) 46	(5.6) 121	(2.3) 250	(3.2) 16	(3.0) 160	(2.0) 157	(2.4) 317
TOTAL	(99.9) 897	(100.2) 635	(100.0; 1532	(100.0) 1127	(100.2) 649	(99.9) 1776	(99.9) 1233	(100.2) 1126	(100.0) 2359	(99.95) 2161	(100.02) 5589	(100.03) 7750	(100.0) 5418	(100.0) 7999	(100.1) 13,417

[1] Numbers in brackets are precentage of column totals.

[2] Because an individual can be assigned more than one of the above diagnoses in a given year, the column totals are not discrete counts of patients.

adjustment reaction patients in that age category, though the numbers are extemely low. There were 635 M.S.I. patients aged 0-4 and only 9 mental health outpatients in that age group. Private practitioners obviously are not in the habit of referring children under the age of five to mental health outpatient facilities.

For the 5-9 age group, the three most frequent M.S.I. diagnoses are conduct disorder, developmental delay, and neurotic disorder. The equivalent outpatient mental health facility diagnoses are acute reaction to stress/adjustment reaction, conduct disorder, and developmental delay. Private practitioners appear either to be much more ready to diagnose conduct disorder in young children than are mental health faciltiies, or else simply see (but do not refer) a much higher proportion of conduct disorder children.

For the 10-14 age group, the three most frequent M.S.I. diagnoses are neurotic disorder, acute reaction to stress/adjustment reaction, and conduct disorder. Their mental health facility equivalents are identical though much more concentrated in the acute reaction to stress/ adjustment reaction category.

For the 15-19 age group, the three most frequent M.S.I. diagnoses are neurotic disorder (accounting for nearly half of all mental disorder diagnoses), acute reaction to stress/adjustment reaction, and special symptoms. For the mental health outpatient facility patients, the three most common diagnoses were acute reaction to stress/adjustment reaction, conduct disorder, and neurotic disorder.

It would appear that private practitioners only rarely refer young patients to outpatient mental health facilities, treating a very wide range of mental disorders on their own. Pediatric psychiatry and neurology are highly specialized fields. While experts feel that many pediatricians generally have some skill and training in these areas, mental health professionals interviewed felt that the average family physician very often does not. Interestingly, while young mental disorder patients make up less than three percent of a family physician's practice on the average (as we have seen), pediatricians interviewed suggested that from 15 percent to 25 percent of their practices involved such cases.

Perhaps, in some cases, family practitioners are referring their young mental disorder patients to pediatricians. It is clear, however, that as the YHCs grow in their ability to deal with the problems of young people, the Local Committees and the Secretariat Staff will need to educate private practitioners as to YHC capacities. It would also be wise to provide continuing medical education on pediatric psychiatry to the Province's family practitioners, and to include in this education an emphasis on when to refer to specialists.

Table 39 combines M.S.I. data on diagnostic categories with data on costs. The single most expensive diagnostic category was that of neurotic disorder ($139,312.74), followed by adjustment reaction/reaction to stress ($118,588.74) and conduct disorder ($82,437.24).

Comparing tables 38 and 39 permits calculation of the cost of treatment of patients by diagnosis and age and sex category. For example, age 0-4 males diagnosed as suffering from a neurotic disorder cost an average of $15.13 to treat, while females in the same age and diagnostic categories cost $13.60 on average. Conduct disorder patients for the entire 0-19 group averaged $54.27 to treat. Depressive disorder, on the other hand, averaged $42.11 per patient. For all 0-19 mental disorder patients taken together, M.S.I. disbursed an average of $43.10 per patient.

TABLE 39 : AMOUNT AND PERCENTAGE OF MSI FUNDS PAID TO PHYSICIANS ON A FEE FOR SERVICE BASIS DURING FISCAL 1981, FOR MENTAL DISORDERS, BY AGE GROUP AND SEX.[1], [2].

DIAGNOSIS	0 - 4			5 - 9		
	Male	Female	Both	Male	Female	Both
Neurotic Disorders. 300	(2.8) $736.42	(3.5) $544.05	(3.1) $1280.47	(6.1) $3331.42	(13.1) $3310.15	(8.3) $6641.57
PSYCHOSES (Schizophrenia, affective psychoses, paranoid states.) 295, 296, 297.	(0.6) 155.87	-	(0.4) 155.87	(0.3) 169.24	(0.5) 123.28	(0.4) 292.52
Other Non-Organic Psychoses. 298	-	(0.2) 32.07	(0.1) 32.07	(0.5) 297.01	(0.2) 50.34	(0.4) 347.35
Childhood Psychoses. 299	(0.7) 175.44	(0.3) 52.36	(0.5) 227.80	(0.9) 499.64	-	(0.6) 499.64
Alcohol & Other Drug Abuse, Dependence & Psychoses. 291, 292, 293, 303, 304, 305.	(0.1) 31.12	(0.3) 53.28	(0.2) 84.40	(0.1) 36.03	(0.04) 10.30	(0.1) 46.33
Special Symptoms, e.g., tics, stuttering, psychalgia, anorexia nervosa. 307	(9.7) 2522.93	(12.8) 1982.44	(10.8) 4505.37	(7.8) 4274.83	(9.7) 2447.11	(8.4) 6721.94
Acute Reaction to Stress. Adjustment Reaction. 308. 309.	(6.4) 1674.72	(6.9) 1070.13	(6.6) 2744.85	(10.9) 5941.73	(11.1) 2796.98	(10.9) 8738.71
Organic Psychotic Conditions. Non-psychotic disorders following brain damage. 294, 310.	(0.2) 57.27	(0.6) 85.74	(0.3) 143.01	(0.2) 83.12	(0.7) 186.22	(0.3) 269.34
Sexual Deviations and Disorders. 302.	(0.2) 39.27	(0.3) 50.07	(0.2) 89.34	(0.2) 122.40	(0.6) 163.21	(0.4) 285.61
Physiological malfunction from mental factors. Psychic factors associated with diseases elsewhere classified. 306, 316.	(0.4) 95.74	(1.0) 149.77	(0.6) 245.51	(0.3) 183.96	(1.1) 287.37	(0.6) 471.33
Depressive Disorder. 311.	(0.04) 10.80	(0.1) 21.60	(0.1) 32.40	(0.6) 357.36	(2.8) 713.44	(1.3) 1070.80
Conduct Disorder. 312.	(25.3) 6363.89	(38.6) 5981.56	(30.9) 12,345.45	(27.3) 15,018.49	(24.6) 6220.63	(26.5) 21,239.12
Disturbance of emotions specific to childhood and adolescence. 313.	(1.0) 254.42	(3.0) 472.40	(1.8) 726.82	(8.7) 4806.79	(5.3) 1333.59	[illegible] 6140.38
Hyperkinesis. 314.	(16.2) 4237.60	(9.2) 1422.00	(13.6) 5659.60	(12.4) 6804.19	(6.8) 1713.35	(10.6) 8517.54
Developmental Delays. 315.	(28.2) 7357.42	(21.1) 3263.34	(25.5) 10,620.76	(18.6) 10,216.92	(15.3) 3857.01	(17.5) 14,073.93
Mental Retardation. 317, 318, 319.	(6.9) 1794.17	(2.1) 320.40	(5.1) 2114.57	(4.5) 2478.08	(7.3) 1845.37	(5.4) 4323.45
Personality Disorder. 301.	(0.1) 38.77	-	(0.1) 38.77	(0.7) 365.91	(0.7) 173.12	(0.7) 539.03
Total	(100.04) 26,105.35	(100.2) 15,501.21	(100.3) 41,606.56	(100.1) 55,027.12	(99.94) 25,243.37	(100.1) 80,270.49

1. Numbers in brackets are percentages of column totals.

2. Fiscal 1981 is the period between 1 April and 31 March 1982, inclusive. However, MSI data refer to date-of-payment of physician rather than to date of delivery of service. Given some degree of lag between service and payment, fiscal 1981 is roughly equivalent to calendar 1981, for present purposes

TABLE 39 (cont.)

	10 - 14			15 - 19			0 - 19	
Male	Female	Both	Male	Female	Both	Male	Female	Both
(15.9) $10,346.16	(25.0) $13,483.59	(19.9) $24,329.75	(24.2) $25,146.41	(35.5) $81,914.54	(32.0) $107,060.95	(15.8) $40,060.41	(30.5) $99,252.33	(24.1) $139,312.74
(0.2) 153.16	(0.4) 208.30	(0.3) 361.46	(10.9) 11,268.06	(6.2) 14,259.51	(7.6) 25,527.67	(4.6) 11,746.33	(4.5) 14,591.29	(4.6) 25,337.62
(0.6) 376.59	(0.1) 36.98	(0.3) 413.57	(0.8) 866.40	(0.5) 1223.32	(0.6) 2089.72	(0.6) 1530.00	(0.4) 1352.91	(0.5) 2882.91
(0.6) 436.23	(0.2) 95.23	(0.4) 531.46	(0.1) 98.18	(0.005) 10.80	(0.03) 108.98	(0.5) 1209.49	(0.05) 158.39	(0.2) 1367.88
(0.1) 563.99	(0.7) 399.31	(0.8) 963.30	(4.5) 4662.74	(1.3) 3090.09	(2.3) 7752.83	(2.1) 5293.88	(1.1) 3553.48	(1.5) 8847.36
(6.0) 4116.78	(8.2) 4390.68	(7.0) 8507.46	(3.8) 3921.20	(9.2) 21,241.65	(7.5) 25,162.85	(5.9) 14,335.74	(9.2) 30,061.88	(7.8) 44,397.62
(16.1) 10,967.40	(24.9) 13,422.24	(20.0) 24,389.64	(20.6) 21,407.36	(26.6) 61,257.58	(24.7) 82,665.54	(15.8) 40,041.81	(24.2) 78,546.93	(20.5) 118,588.74
(0.2) 143.08	(0.1) 72.32	(0.2) 215.40	(0.5) 534.76	(0.1) 295.32	(0.2) 830.08	(0.3) 817.63	(0.2) 640.20	(0.3) 1457.83
(0.03) 21.60	(0.04) 21.60	(0.04) 43.20	(0.6) 628.38	(0.2) 512.01	(0.3) 1140.39	(0.3) 812.25	(0.2) 746.89	(0.3) 1559.14
(0.7) 448.64	(1.4) 752.55	(1.0) 1201.19	(0.4) 446.25	(0.4) 927.29	(0.4) 1373.55	(0.5) 1174.60	(0.7) 2117.58	(0.6) 3292.18
(2.5) 1677.53	(2.5) 1347.57	(2.5) 3025.10	(10.0) 10,420.31	(9.2) 21,159.15	(9.4) 31,579.46	(4.9) 12,466.00	(7.2) 23,241.76	(6.2) 35,707.76
(30.3) 20,679.59	(19.8) 10,551.47	(25.6) 31,231.06	(10.0) 10,345.17	(2.9) 6776.34	(5.1) 17,121.51	(20.9) 52,907.14	(9.1) 29,530.10	(14.3) 82,437.24
(8.7) 5912.95	(7.3) 3934.30	(8.1) 9847.25	(0.9) 889.42	(1.1) 2449.73	(1.0) 3339.15	(4.7) 11,873.58	(2.5) 8190.52	(3.5) 20,064.10
(6.0) 4095.29	(1.5) 807.72	(4.0) 4903.01	(0.2) 241.93	(0.1) 165.24	(0.1) 407.17	(6.1) 15,379.01	(1.3) 4108.31	(3.4) 19,487.32
(7.7) 5240.54	(4.1) 2223.26	(6.1) 7463.80	(1.4) 1479.76	(0.1) 248.68	(0.5) 1728.44	(9.6) 24,294.54	(3.0) 9592.29	(5.9) 33,886.83
(3.0) 2025.96	(2.4) 1289.68	(2.7) 3315.64	(1.6) 1637.02	(0.4) 842.00	(0.7) 2479.02	(3.1) 7935.23	(1.3) 4237.95	(2.1) 12,173.18
(0.8) 561.36	(1.5) 817.25	(1.1) 1378.61	(9.5) 9822.18	(6.1) 14,066.19	(7.1) 23,888.37	(4.3) 10,338.22	(4.6) 15,056.56	(4.4) 25,394.78
(99.43) 68,256.85	(99.34) 53,354.05	(100.04) 122,120.90	(100.0) 103,316.14	(99.305) 230,440.14	(99.53) 334,256.28	(100.0) 253,215.96	(100.25) 325,039.37	(100.0) 578,255.33

Summary of Chapter IV, "What We Are Doing Now: Statistics"

1. Since mental health facilities often fill out forms in a highly variable manner, and since these forms could yield data important for evaluation and planning, there should be centalized training across mental health facilities of staff responsible for routine forms dealing with inpatients and outpatients.

2. These forms are in need of revision in order that they yield more reliable data. The Department of Health should creat a committee to review its data collection and analysis procedures with respect to psychiatric outpatients. This committee should include at least one professional researcher likely to use the resulting data in program research; one administrator likely to use the data in administering mental health services; and one individual whose daily work requires him/her to fill out these forms. The Committee should begin its work by focusing on the purposes for which data are to be collected.

3. Mental health staff should be provided with uniform training in the use of psychiatric diagnostic categories. (This recommendation is expanded in chapter XI.) That training should pay special attention to autism.

4. If mental health facilities (Youth Health Centres) are to cooperate closely with social service agencies then they must have considerable expertise on staff in the management of young people suffering from conduct disorder.

5. The number of age 0-19 individuals in Nova Scotia has dropped from 320,965 in 1971 to 284,240 in 1981. This was a fall of 11.4 percent. In 1971 the 0-19 age group comprised 40.7 percent of the total population, while in 1981 it was 33.5 percent. This does not mean that services for young people should be reduced, since they quite likely were inadequate in 1971 and continue to be so today. Moreover, whatever proportion of the population our young people constitute, they are all the children we have.

6. There are sharp county by county differences in outpatient mental health facility utilization rate. The highest rates are 15.8 per thousand 0-19 year olds in Kings County, followed by Halifax and Lunenburg counties each with rates of 14.4 per thousand. The lowest rates belong to Victoria County with 2.1 per thousand and Cape Breton County with 4.9 per thousand.

7. Mental health outpatient populations are heavily under-represented by the 0-4 age group (in comparison with their share of the general population), and 5-9 year olds only somewhat less so. Adolescents, however, are over-presented. Males are more likely than females to use outpatients mental health facilities in the Province as a whole, though there is much variation from county to county. The use of facilities by males peaks with the 10-14 age group and then declines, while for females it continues to rise through ages 15-19.

8. Nova Scotia in 1981 and Saskatchewan in 1978 (the latest year for which data were available) had precisely the same rate of utilization of mental health facilities by young people (controlling for population differences).

9. Mental health facilities, like counties, show great variation in the proportion of their outpatient caseload in the 0-19 age group.

10. For all provincial outpatient mental health facilities, for the 0-19 age group, psychologists accounted for 32.6 percent of initial assessments, psychiatrists for 23.5 percent, and social workers for 20.9 percent. Young males were more likely to be assessed by psychologists than were young females.

11. The average proportion of all contacts which involved a psychiatrist was 12.5 percent. For psychologists it was 41.7 percent, and for social workers 26.1 percent. Thus, only about one eighth of actual contacts in mental health centres dealing with young people involve psychiatrists, more than twice that many involve social workers, and better than three times as many involve psychologists. The psychiatrists are also more likely to see the older than the younger patients, the psychologists more likely to see the younger than the older. Social workers tend to see adolescents in the 15-19 age group.

12. There was great variation among facilities in terms of total amount of staff time per patient/client, one averaging 148.9 minutes, another 498.9 minutes. There was similar variation as to the amount of time received by the various age groups.

13. A "contact" involves time spent either with or on behalf of a patient/client. Less than 2 percent of contacts, on the average, were with a young person's family physician. It is clear that it is unusual for the family physician to pay a substantial role in a young person's treatment plan.

14. More than 90 percent of contacts take place at the mental health facility, rather than in another setting.

15. Some diagnostic categories are much more demanding of staff time than are others, depending on the patient's/client's age.

16. It is quite likely that a very small proportion of patients take up a disproportionate amount of staff time.

17. Many facilities have a minimal range of treatment alternatives for young people, usually lacking both play therapy for young children and group therapy for adolescents.

18. Chemotherapy and electroconvulsive therapy are both rate, the latter in particular. Surprisingly, so too is behaviour therapy.

19. Depending on the facility, from 26.9 to 92.4 percent of patients had been treated previously, in 1981.

20. Males are more likely than females to have been referred for "socially disruptive behaviour". Females are more likely than males to have been referred for "self-oriented disturbance".

21. There is sharp variation among facilities in the frequency with which particular diagnoses occur. One facility finds that "developmental delay" occurs in 24.8 percent of all 0-19 outpatients, while another finds that diagnosis accounts for only .8 percent of cases. Overall, 24.7 percent of outpatients are essentially undiagnosed in that they are given extremely vague diagnoses (e.g. "unspecified mental or behavioural problem").

22. The sharp jump in the outpatient population that occurs between the 0-4 and 5-9 age categories suggest that family practitioners often fail to identify and refer serious problems in young children (the "he'll grow out of it" syndrome), so that only when the child enters school does he or she get referred to a mental health facility.

23. Seriously ill young people—those suffering from psychoses and organic brain damage, as well as those suffering from disorders stemming from alcohol and other substance abuse—total only 3.2 percent of outpatients. The vast majority suffer from much less grave problems.

24. Private physicians appear only infrequently to recognize childhood and adolescent depression, though the consensus of pediatric psychiatrists is that this disorder may represent a serious problem.

25. A large proportion of young people, diagnosed as suffering from "acute reaction to stress" and "adjustment reaction", are having "problems of living" rather than deep-seated mental illness and might well be treated not at a mental health facility but by a clergyman, social service agency, private practice social worker or psychologist; or by a family friend. Mental health services, in short, both overlap and complement other sources of aid in the community and therefore must cooperate not occasionally but intimately with these other agencies.

26. There is good reason to believe that early childhood autism is being sharply underdiagnosed.

27. In 1981, this Province's mental health facilities (inpatient and outpatient) served approximately 4,000 young people aged 0-19.

28. Counties with low mental health facility utilization rates for young people do not compensate, as might be expected, with high rates of private physician utilization for mental disorder.

29. More than 3 times as many young people were treated by private physicians for mental disorders as were treated by the mental health facilities, in 1981.

30. Victoria County children and adolescents have the lowest rate of both private physician and mental health outpatient facility utilization for mental disorders. They appear to almost never use mental health services.

31. For the 15-19 age group, females receive psychiatric disorder diagnoses by M.S.I.-reimbursed physicians approximately three times as frequently as do males in their age group. It is unclear why this should be so and the matter requires further research. However, Secretariat Staff should consider offering some services specifically for this group.

32. Nearly one of every twenty children and adolescents in Nova Scotia, in 1981, was treated for a mental disorder of some kind.

33. Despite the fact that private physicians see far more mental disorder young patients than do the mental health facilities, for the 0-19 age group as a whole mental disorder diagnoses made up only 4.6 percent of all patients seen in 1981 (data refer to private physicians plus I.W.K.H. physicians for whose services M.S.I. is billed).

34. The 4.6 percent of patients referred to above accounted for only 2.8 percent of M.S.I. fee-for-service expenditures, or, for 1981, some $578,255.33. Apparently, it is less costly for physicians to provide mental health than other medical services.

35. The most common physicians' diagnoses for young people were neurotic disorders, acute reaction to stress/adjustment reaction, and conduct disorder, in 1981. These were also the most frequent diagnoses for young people seen at mental health facilities.

36. For all 0-19 mental disorder patients taken together, M.S.I. disbursed an average of $43.10 per patient, in 1981, suggesting that mental disorders are not particularly expensive to treat.

37. Private practitioners only rarely referred young patients to outpatient mental health facilities, treating a very wide range of mental disorders on their own.

38. As YHC capacities grow it will be necessary to keep local physicians informed of these facilities' increasing range of abilities.

39. Continuing medical education on pediatric and adolescent psychiatry should be provided for the Province's family physicians, with an emphasis on when to refer to specialists. (This recommendation is also made in chapter XI.)

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Chapter V

ADMINISTRATIVE REORGANIZATION

Along with fire and the wheel, bureaucracy is one of the great inventions of our species. There is no other way to organize large-scale society: face-to-face relationships do not work when hundreds of thousands of people are involved. But fire can destroy and the wheel lead to collision. And bureaucracy, too, has its share of problems.

Organization By Function vs. Organization By Age Category

We can organize government services to people by function, or we can organize them on the basis of age group served. For example, we might have one government department in charge of all children 0-14, another in charge of the 15-34 age group, and so on. Each department would look after all the needs of its group, whether these were in the area of housing, or health, or jurisprudence, or whatever. This kind of bureaucratic organization is rare because it leads to endless and inefficient duplication of function. For each age category we would need a sort of mini-department of health, a mini-department of social services, a mini-department of so many things that we would end with a sort of mini-provincial government.

Thus, Canada's provinces generally organize services on the basis of function. We have one department responsible for health needs, another for social services, another for labour, one for lands and forests, etc. Only education appears, at first glance, to be age-regulated. But Nova Scotia's Department of Education is not responsible for children in any global sense—it is responsible only for educating them. Moreover, its education responsibilities are not limited to children, since it must also concern itself with higher education. There is no department in this province that is organized solely on the basis of the age of the people it serves.

But many of the problems of children and adolescents discussed in chapter II result from our bureaucratic organization by function rather than by age group. As we have seen, no one department or agency has responsibility for all of the young person's needs. Instead, one facility is concerned with his or her health, another with protecting the young person from abuse, another with dealing with any offenses against the law, and another with his or her education. The resulting services are necessarily fragmented. Yet, especially for the child or adolescent with problems, services from a number of sources are likely to be needed. These services tend to be uncoordinated--each does its own small task largely in isolation from the others, so that parents and child may feel like so many ping-pong balls being bounced from one agency to another.

Such problems are endemic to bureaucratic organization by function. They occur throughout the world, wherever large-scale societies attempt to provide their people with basic health and social services. They are not the result of malice, stupidity, or bureaucratic insensitivity. There is nothing particularly "Nova Scotian" about them, for studies from province-after-province report the same difficulties (as was discussed in chapter II).

The obvious "solution" to the problem of fragmentation of services caused by bureaucratic organization by function is to move in the other direction, towards services organized by age group. The young, like senior citizens, often have needs which are not well-served by functionally organized bureaucracies. Why not regroup services now provided by the Departments of Health, of Social Services, and of Education into a single department solely concerned with young people? Nova Scotia has, in the past, at least flirted with this idea.[1] More recently (1977), Ontario has created a subdepartment of Children's Services as part of its Ministry of Community and Social Services. Should we follow the example of Outario, and would we thereby solve once and for all the problem of fragmented services for young people?

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[1] The late sixties-early seventies "Commission for Youth."

Bureaucracies organized in terms of age groups have their own problems, as we have seen, problems involving duplication of effort and lack of coordination of policy among personnel providing identical services for different age groups. For Nova Scotia, the crucial question is this: would the reorganization of services for young people by age category rather than by function solve more problems than it would create?

Costs of Reorganization

Ontario had given itself a realistic ten years to make its reorganization work, but since it altered its plans and had largely discontinued its experiment by the end of 1982, it would be unfair to try to evaluate its relative success. Moreover, Ontario did not include education in its Children's Services division, so it is not really an adequate model of organization by age category. But there are some lessons which can be learned from Ontario, and from informal discussion of the age group reorganization option with "front line" staff from Nova Scotia's health and social services agencies. These lessons suggest that, were Nova Scotia to reorganize its services along age lines:

(a) The actual reorganization would probably be highly disruptive as established programmes and personnel were reshuffled. The process would absorb large quantities of everyone's time and energy, and it would be several years before relatively smooth functioning could be reestablished.[2]

(b) Some personnel would be highly resistant to the change, a major problem because individuals with expertise in social and mental health services for young people are in short supply throughout North America and have little difficulty, for the most part, in finding new employment elsewhere. In general, medical personnel (nurses, child psychiatrists) would be quite reluctant to be employed by what they might perceive as a social service rather than health department, while (clinical) child psychologists are likely to resist working under medical auspices. Senior administrators are likely to resist a reorganization which they suspect of reducing their areas of authority and responsibility.

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[2] The considerable controversy which erupted over the Walker Commission recommendations for the amalgamation of school boards into larger districts suggests the amount of energy likely to be expended in the creation of a Department of Children's and Youth Services.

(d) A newly created youth department would tend to have problems of coordinating its services with organized-by-function departments, since its operations would necessarily overlap with these.

In short, drastically reorganizing the bureaucratic structure of services for children and adolescents means exchanging one set of problems for another. It is no panacea. Rather, it is a path we should take only if serious efforts to provide coordination of services organized as they are now, fail. But it may be possible to amend the present structure in such a way as to correct its major problem—lack of coordination. The Youth Secretariat/Local Committee model sketched in the next chapter is one way to solve our current fragmentation problems in providing services to young people. It is a means of maintaining government's attention to the needs of children and adolescents.

The Youth Secretariat/Local Committee Model

Rather than detaching all services for children and adolescents from their parent agencies in order to form a new provincial department, the Youth Secretariat/Local Committee model calls for coordinating existing services regardless of which department is providing them. But coordination to be effective must be coordination at all levels. Thus, the model calls for a two-tier coordinating structure.

The top tier is the Youth Secretariat itself. This is a cabinet-level body consisting of the ministers of Health, Education, and Social Services, their respective deputies, and a senior level administrator from each department who is primarily concerned with children and adolescents. In the case of the Department of Health it would be advisable to create a director of psychiatric mental health services for children and adolescents; in the case of the Department of Social Services, the Administrator for Family and Children's Services would presumably be a member of the Secretariat. The Department of Education's senior administrative secretariat member would be whichever individual has primary responsibility for special education and guidance services.

The Youth Secretariat in many ways is simply an elaboration of the present HESS Committee (made up of the ministers and deputy ministers of the departments of Health, Education, and Social Services). It would be comparable to the Senior Citizens' Secretariat (whose members are the ministers of Health, Social Services, Labour, Housing and Municipal Affairs). The Youth Secretariat differs from the HESS Committee and the Senior Citizens' Secretariat in several crucial respects, however. It is to have a director and staff, for example, the responsibilities of which are outlined below. Moreover, it will have a lower tier in the form of the Local Committees.

The Youth Secretariat will consider only those matters which affect more than one department. For example, it would not deal with education policies per se, these remaining the province of the Minister of Education. However, it might consider the special services offered by the school systems, since these often overlap with services provided directly or indirectly by the Department of Health.

The Local Committees will be regional in nature. For convenience, the catchment area of each existing mental health out-patient facility will initially be defined as a local region requiring a Local Committee. (These boundaries will, however, be negotiable, as will be discussed shortly). For the Halifax-Dartmouth area, the Metropolitan Mental Health Planning Board and its Children's/Adolescents' Committee in particular will serve as Local Committee (a function it is in effect fulfilling already and which will be discussed in greater detail in chapter VIII).

Each Local Committee will have both a general membership and a working executive. The general members will number 30-35 and their primary qualification will be a strong concern with the problems of and services for young people. The membership will include the directors and some senior staff from all local health (including the regional Health Unit), social service, and educational facilities providing services to children and adolescents. Other members will be drawn from among local physicians (pediatricians and child psychiatrists in particular), the police, clergymen, and representatives of voluntary organizations (e.g., Big Brothers/Big Sisters, parent-teachers associations, the Canadian Association for the Mentally Retarded and the Canadian Mental Health Association). The inclusion of several adolescents as members would not be inappropriate.

Each Local Committee will meet two to three times a year and will have general responsibility for policy planning and coordination of services for children and adolescents within its region. It will have an elected chairman who will also serve as chairman of the working executive.

The working executive will meet on a monthly basis. It will consist of approximately eight people chosen from the Local Committee's general membership on the basis of their demonstrated interest and readiness to contribute (thereby ensuring the quality and dedication of the working executive). The working executive will make recommendations to the Local Committee on all matters concerning the planning and coordination of services for young people. It will be charged not only with developing plans but with generating regional consensus for them.

Consensus will be necessary because the Local Committee will be expected by the Secretariat and Secretariat Staff to endorse all proposals from its region regarding children's and adolescents' services (excluding those which primarily affect only a single provincial department, e.g., the construction of a new school building). Thus, plans for day care centres, residential facilities for adolescents, youth guidance centres, crisis intervention services and similar programs will ordinarily require approval by the Local Committee. The working executive will not be unaided in seeking consensus, however. The Secretariat Staff members are expected to serve in part as mediators and negotiators, facilitating communication among the various groups of each region and providing independent expertise as to the suitability of the varied options available for services for children and adolescents.

The Secretariat Staff is to consist of three to six individuals and have a director of senior administrative rank. That the director be of senior rank is essential as he or she will be expected to confer with and advise ministers and deputy ministers. The Staff members will require, as we have seen, considerable expertise in the processes of mediation and negotiation--the kind of skill a professional labour conciliator must have. In addition, the staff members require knowledge of and experience in the delivery of services to young people. Ideally, at least one staff member should himself or herself be a child psychologist or psychiatrist.

The role of the Secretariat Staff will be particularly important during the inception of the Local Committees. The staff will be expected to initiate this process, in collaboration with the directors of facilities currently providing services to children and adolescents. Staff will be charged with ensuring the breadth of the membership of the Local Committees. In addition, they will have the authority to arbitrate boundary disputes among Local Committees. Such disputes are inevitable, since the various provincial departments and service agencies have varying rather than coincident boundaries.

The Secretariat Staff is to have no programs of its own to administer. Its functions are limited to policy planning and evaluation, coordination of programs affecting young people, and providing consultation and other services to the Local Committees (such as recruitment of personnel and the organization of special training programs, and other tasks which are most efficiently handled centrally). The Secretariat will also aid in the setting forth of priorities. In performing its functions, the Secretariat Staff is to make full use of professional epidemiological, sociological, and evaluation research (as discussed in chapters III, VII, and XII). Final say on all matters of policy and budget will, of course, remain with the Secretariat itself, that is, with a cabinet committee. (And with the First Minister, needless to say.)

The Secretariat Staff will aid the Local Committees but not control them. The various agencies in each region will continue their usual lines of authority and will retain their present advisory bodies. Secretariat Staff will in part provide a wider perspective and a broader knowledge of policy options.

But wherever the Secretariat Staff sees that coordination is not occurring (and Staff members must travel frequently and speak not just to directors of facilities but with "front-line troops" and with troubled young people and their families as well), or that policy guidelines are not being met or that there is a lack of willingness to cooperate with other facilities, then the staff must make appropriate recommendations to the Secretariat. Such recommendations might well deal with budgets of particular facilities and with personnel.

The Youth Secretariat/Local Committee model is intended to permit the tailoring of services to local needs and wishes while maintaining throughout the Province a shared minimum level of facilities, programs, and policies. It is also designed to provide expert aid to the locality whenever necessary. In order to strengthen the model and give it both longevity and legitimacy in the eyes of the mental health and social service community it should be implemented through legislation.[3]

How Much Would the Youth Secretariat/Local Committee Model Cost to Implement?

This report is being prepared during a time of sharp financial constraint: how expensive would the Youth Secretariat/Local Committee Model be? The answer is that it could be implemented at relatively little cost. Though it would be preferable to provide it with a reasonable budget, all personnel needed for the Secretariat Staff, including the Director, could be seconded or transferred from provincial departments. There is no question but that experienced personnel do exist. The drawback here, however, is that such personnel might be suspected of bias when, as would happen, they would be expected to mediate disputes and make recommendations in which their "home" department was an interested party. However, depending on the particular background of the individuals involved, this drawback might not be insurmountable. If seconding of staff is used then the cost of the Youth Secretariat would be that of one or two secretaries, office space and equipment. (Should the Department of Health accept the recommendation to appoint a Director of Child's Psychiatric Mental Health Services then the cost would be somewhat greater.)

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[3] Chapter VI includes examples of how the Local Committee would resolve actual problems.

The Local Committees, on the other hand, should in no case be costly. They would consist largely of individuals whose salaries are already paid, directly or indirectly, by provincial departments. What would be needed here would only be a directive from the ministers of Health, Education, and Social Services that participation in a Local Committee was to be considered a responsibility of all personnel funded by their respective departments, one of importance equal to the provision of direct services to clients and patients. Ideally, a full-time secretary should be provided for each Local Committee. However, a part-time secretary seconded from an existing facility would suffice.

What If It Does Not work?

Suppose that, four years after the inception of the Youth Secretariat/ Local Committee Model, there are still problems of fragmentation and lack of coordination? This may well be the case after all, for many factors could destroy the effectiveness of the model. Aside from the possibilities of strong resistance from local regions and errors on the part of Youth Secretariat and Staff alike, the major weakness of the model stems from the "two masters" problem. It is possible that administrators of facilities providing services to youth will find themselves torn between the wishes of their own boards or staff on the one hand, and the wishes of their colleagues in other agencies on the other. Nova Scotia health, social service, and education facilities tend to have strong traditions of local autonomy and the Secretariat and its Staff may find their influence less than they might wish.

It is important, four years after the model is put into effect, that an evaluation study be conducted independently to determine the relative success of the model. "Success" here would mean success in: reducing or eliminating fragmentation of services; the setting up of clear regional priorities for facilities; adherence to policy guidelines and provision of minimum services; and evidence of staffing decisions and choice of modes of intervention being made on scientific grounds (see chapter VII for discussion of "scientific" in this context).

Should it be clear that the Youth Secretariat/Local Committee model has failed, the Province must appoint a Task Force to plan the creation not of a Youth Secretariat but of a Department of Children's and Adolescents' Services. Despite the serious drawbacks of such a reorganization, it would certainly be preferable to continuing to provide services in the current manner.

Summary of Chapter V, "Administrative Reorganization"

1. A cabinet-level Youth Secretariat is recommended, working in conjunction with Local Committees.

    a. The Secretariat would consist of the Ministers of Health, Education and Social Services; of their deputies; and of an appropriate senior administrator from each Department.

    b. The Department of Health requires a director or coordinator of psychiatric mental health services for children and adolescents. This individual would serve as a member of the Youth Secretariat.

    c. It would have a Staff of 3-6, headed by a senior administrator.

    d. It should have no programs of its own but would serve to coordinate existing programs affecting services for children and adolescents, facilitate communication and policy planning between the Local Committees and the Secretariat, uphold minimum standards of service, make policy recommendations to the Secretariat and evaluate the appropriateness and effectiveness of existing policies.

    e. The Local Committee would be regional in nature and include social service, educational and mental health professionals, and private individuals, with a general membership of 30-35. In the Metro area, the Metropolitan Mental Health Planning Board would perform the function of the Local Committee.

    f. The Local Committees would be charged with general planning of services for their respective regions. They would meet 2-3 times each year.

    g. Each Local Committee would have a working executive of perhaps eight individuals who would meet on a monthly basis.

    h. The Local Committee and the Secretariat Staff would be expected to analyze, endorse or reject any proposal affecting children's and adolescents' services in a particular locality.

    i. Staff would meet regularly with Local Committees, providing a wider perspective, mediating disputes, and advising. Staff would have only a strictly limited power over Local Committees (e.g., arbitrating boundary disputes among Local Committees). The influence of Staff would flow in large measure from its function of advising the Secretariat on programs, budgets, and priorities with respect to services for children and adolescents.

    j. Final decisions on all programs would remain in the hands of the appropriate cabinet ministers.

2. If financial constraint so required, the Secretariat Staff could consist of individuals seconded from existing programs. (The Local Committees would not in any case require additional funding). Thus, depending on the manner in which it was implemented, the proposed Youth Secretariat/Local Committees model could be implemented at relatively little cost.

3. If a review study four years after the inception of the Youth Secretariat/Local Committee model found that major problems in the provision of services for children and adolescents remained, then a Task Force should be appointed to put all or most such services under a single administrative unit.

Chapter VI

THE YOUTH HEALTH CENTRE MODEL

The "Youth Health Centre" (YHC) model refers to a flexible range of ways of delivering mental health services to young people and of coordinating these mental health services with related services. At a maximum, the YHC model means a facility physically and programmatically separate from adult mental health services and staffed by child pyschiatrists and psychologists as well as other experts in the problems of childhood and adolescence. At a minimum, the YHC model calls for a clinic of an existing psychiatric facility staffed by whichever current personnel have the most expertise in the problems of children and adolescents and providing a major portion of its services in settings physically separate from the adult mental health facility. Such settings might include a hospital, school, social service agency, multiservice centre, day care centre, or other locale that children or adolescents can visit without stigma.

Goals

Long-term goal: a maximum YHC in every part of the Province must be a long-term goal of the Youth Secretariat. But given the continent-wide shortage of expertise in children and adolescents, and given financial constraints, it would be most unrealistic to recommend the immediate creation of as many maximum YHCs as there are now adult-oriented mental health facilities. It would be equally unrealistic to fail to appreciate the need for such facilities and not begin now the planning necessary to have such a number within ten to fifteen years.

Medium-term goal: the creation of one or two maximum YHCs in particularly populous but underserved areas of the Province (e.g., Cape Breton) is a realistic medium-term goal. In two to five years these YHCs could be serving not just their home region(s) but the Province as a whole in that they would be pilot projects, experiments showing us how to develop Nova Scotian YHCs.

Short-term goal: for the short-term, however, we must content ourselves with creating minimum YHCs, that is, branches of existing mental health facilities operating somewhat in the manner of satellite clinics. Since these will utilize current personnel and will borrow physical facilities, they can be organized immediately and at little cost.

Guiding Principles

A guiding principle of the YHC model is that mental health facilities for young people must be kept physically, budgetarily and programmatically as separate as possible from those for adults. It is stigma which explains the "physical" aspect of this principle.[1] As we have seen (chapter II), mental health professionals are in a very poor position to appreciate the extent to which their facilities are stigmatized. Parents are often frightened to bring their children to the same facility that treats the visibly psychotic, while peer-sensitive adolescents are extremely reluctant to risk the reputation arising from going to "that" place. Mental health professionals can only be aware of those who do brave the stigma involved: they have no contact with those whom stigma has kept at home.

A second YHC guiding principle is that there must be no competition between adults and young people for staff time or choice of services to be provided. Fortunately, the separation of children's/adolescents' facilities from those for adults, necessary to reduce stigma, also helps to reduce competition. In general mental health facilities, older and younger people compete first for type of staff to be recruited and second for staff time.

Directors of Nova Scotia's mental health facilities almost always consider themselves short-staffed: it therefore seems to make sense for the director to seek personnel who can deal with a wide range of age-groups rather than with just one. Unfortunately, treatment of young people requires extensive specialized training--the general psychiatrist and adult-oriented psychologist and social worker lack the appropriate expertise. While many mental health staff members interviewed explained this fact quite clearly, it nevertheless conflicts with the director's needs: the wider the age range a staff member can "cover" the more efficiently that staff member can be utilized. The years of childhood may be "long, long years" but they are nevertheless fewer in number than the years of adulthood. While larger facilities may feel that they can afford to have some specialized staff, smaller facilities consider this to be a luxury.

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[1] The "budgetary" aspect of the guideline is discussed in chapter III.

For facilities lacking expertise in children and adolescents a circular process ensues. Family physicians and other sources of referral soon learn from experience and word-of-mouth of the facility's lack of expertise with younger age groups. They therefore either treat these patients themselves or refer them directly to Metro facilities. As a result, the local facility's director experiences no referral-pressure to recruit experts in the care of children and adolescents. There are usually enough older referrals to fully occupy and even burden existing staff, so the hiring of child/adolescent experts becomes locked in as a secondary priority. The director seeks more generalist staff to serve the adult referrals already being received, rather than specialists to serve the younger referrals which are not, now, being made.

Competition over staff time is a less subtle problem. For example, let us suppose two referrals are made to a general mental health facility, one involving a depressed and possibly suicidal adult, the other a child with a record of truancy. The adult will probably be given a much earlier appointment than the child: truancy hardly seems as grave a matter as suicide.

But much truancy actuallly reflects a school phobia. The child may find the school itself terrifying, or may fear separation from the parents during the school-day. Such school phobias (according to experts consulted) become more difficult to treat every day therapy is delayed. Ultimately, they may grow into full-blown cases of agoraphobia. The child is likely to drop out of school, regardless of actual ability level. Thus, delayed treatment of "truancy" may have drastic and long-term consequences for a young person.

The director of the general mental health facility may or may not be aware of the potentially grave results of delaying treatment of truancy, but in either case he/she is in a "no-win" situation. The needs of the adult referrals are also legitimate and a long wait for an appointment here, too, may have grave consequences. As a result, children and adults tend to be given appointments with what may be an ill-advised equity.

The school phobia example is in many ways typical of the problems children have. The sooner treated, the more effectively treated. In many cases of child abuse and certain other acute conditions, therapy (or at least assessment) should take place instantly and a delay of even days may sharply compromise the effectiveness of treatment. But it is difficult enough for mental health facilities to decide which adult among adult referrals should be seen first, or which child among referrals of children. To refer both children and adults to a single mental health facility with a single staff is to demand that psychiatrists and psychologists and social workers be Solomons. It makes far more sense to separate mental health services for young people—at least programmatically—from those for adults.

The YHC model reduces both staffing and staff-time competition between the older and younger patient/client. It does this by ensuring that the budget for mental health and related services for children and adolescents, for each mental health facility, is distinct and "non-portable" within the general mental health budget. No facility's administrator or director must be able to transfer funds allocated for children and adolescents to other age groups. Mental health budgets in hospital-based facilities are already "non-portable". With the minimum YHC model, the 0-19 age group would enjoy a non-portable budget within this non-portable budget. Establishing this "youth budget" would be an early step in implementing the YHC model recommendation and will be discussed below.

Do we have any reason to believe that YHCs guided by the two principles discussed above would attract many young people? The great success of the Atlantic Child Guidance Centre is strong evidence of the demand for mental health facilities specifically for children and adolescents. Indeed, some professionals interviewed suggested not a network of youth health centres but of guidance centres, perhaps modeled after the ACGC.

But the YHCs recommended in this Study are not intended just to duplicate the ACGC. The ACGC has been able to provide a wide variety of non-medical services for its clients while relying on the Izaak Walton Killam Hospital and Nova Scotia Hospital for psychiatric and neurological services.[2] YHCs will exist only outside the Metro area, however, where they will not be able to refer elsewhere as readily as can the ACGC. They thus will find it necessary and useful to offer a broader range of services than has been the practice of the ACGC, and to be more oriented toward health problems in general than would be expected of a guidance centre. Thus, YHCs should have not only child psychiatrists on staff but, if possible, pediatricians. (This topic is discussed more fully elsewhere in this chapter.)

Implementing the YHC Model

The Youth Secretariat and its Staff, as well as the Local Committees, must be established prior to (or at the same time as) the YHCs. This is because they will have a role in organizing YHCs. The first step in creating the YHCs themselves, however, will be budgetary.

Budget

In order to reduce staff competition among age-groups, a portion of the psychiatric services budget of each existing, non-Metro mental health outpatient facility must be "ear-marked" for the 0-19 age group and made non-portable. That portion should reflect the proportion of a facility's outpatient efforts currently devoted to young people. Tables 9, 10 and 14 in chapter IV provide a breakdown by age group of facility effort in terms of number of contacts and staff time. These tables are therefore a basis for discussion of allocating the "youth services" budgets. The actual budgetary decisions must be the responsibility of the Department of Health, in consultation with the operators of mental health facilities and the Secretariat Staff.

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[2] The ACGC has increased its psychiatric staff time during the course of this study. For further discussion of the ACGC, see chapter VIII.

It is not recommended that services now provided to adults be curtailed in order that services to young people be increased. It is expected that, in the future, the existence of a separate budgetary item for mental health services for young people (when combined with the existence of a Youth Secretariat and Staff aware of this age group's special needs and with Local Committees serving in effect as a sort of youth constituency) will have the net effect of increasing the total resources available for the 0-19 age group.

Staffing

Budget allocations are only part of the story: how can a mental health facility eliminate competition among age groups for staff time? Each facility, with the help of the Secretariat Staff, must determine which of its people are best qualified for and interested in serving the 0-19 age group. These individuals will make up the initial YHC staff of a "minimum" YHC. The proportion of total facility staff time represented by this YHC staff should be roughly equal to the newly non-portable 0-19 portion of that facility's budget. Some members of this "minimum YHC" staff will be assigned to work full-time with children and adolescents, others only part-time. Eventually, most YHC staff will give most of their time to the 0-19 age group.

In many cases, it will be found that this "best qualified and interested" group can provide only a fraction of the range of needed services discussed below. Often, it will be found that the group does not include a psychiatrist, or that its expertise is concentrated in the adolescent rather than child age range. Some staff members may even find themselves assigned to devoting more time to the 0-19 age group than they would prefer simply because they are the best qualified of current personnel. Such problems may occur but, with the help of Secretariat Staff, are solvable.

For example, lack of a child psychiatrist is perhaps the most serious potential lack of the minimum YHC staff. The long-term solution obviously involves recruitment. But in many cases a pediatrician can fill the gap left by the missing psychiatrist. Pediatricians today are increasingly interested in the "new morbidity", that is in behavioural, emotional, and family problems of children (Goldberg et al., 1979; Nader et al., 1981). A pediatrician is not a replacement for a child psychiatrist, of course, but (in the opinion of several child psychiatrists interviewed) is likely to be better prepared to recognize and treat psychiatric and related problems of young people than are many general psychiatrists. The Youth Secretariat and the Department of Health must aid the operators of mental health facilities in devising a standard form of contractual relationship between the facility (or the YHC aspect of it) and a pediatrician in the region. Should no pediatrician be available, it is possible that some family practitioners may be suitable substitutes. But YHCs must have physicians attached to them and must be in a position to ensure that these physicians be reimbursed for accepting YHC patients directly, without a family practitioner's referral. This last recommendation is particularly important, given the YHCs responsibility for long-term monitoring and follow-up of patients (discussed below).

Touring child psychiatrists, psychologists, and pediatricians can also do much to make up for the specific lacks of a short-staffed YHC. Both the Izaak Walton Killam Hospital and the Atlantic Child Guidance Centre currently sponsor consultation in outlying areas of the Province. With the aid of the Secretariat staff, part of the process of creating YHCs should include organizing both regularly scheduled as well as special consultation visits on the part of specialists. In addition, a YHC lacking a specific skill should, again with the aid of Secretariat Staff, arrange a formal relationship with a Metro-based child/adolescent specialist who would agree to make himself/herself available for telephone consultation. The goal is always to treat the child or adolescent in the community. Emergency cases with which the YHC could not cope, however, would be referred directly to Metro (as is now the practice).

Another means of mitigating staff shortages is to make use of existing staff as efficiently as possible. To a considerable extent, this means reserving the physicians, the child psychiatrists in particular, for two tasks: initial assessment, and treatment of the mentally ill, that is, those who are psychotic or suffering from organic brain damage. In addition, the physician must necessarily participate in the treatment of those requiring drug therapy. But since the child psychiatrist is both the rarest and (for the taxpayer) most expensive of children's and adolescents' mental health professionals, other personnel should routinely provide most other treatment. Tables 12 and 13 in chapter IV show that this is indeed currently the practice, with psychologists and social workers providing the preponderance of treatment of young people at mental health facilities.

Some physicians have been trained to believe that even in a multidisciplinary setting and even in a case where medication plays little or no role in treatment, the physician by virtue of having had any contact whatsoever with a patient automatically assumes responsibility for supervising that patient's treatment.

This is not to be the case with the YHC. Rather, it is the staff of the YHC as a whole which has responsibility for each patient/client, and not any one profession within that multidisciplinary staff. Physicians along with other professionals should of course participate in treatment planning.

No matter what measures may be taken to mitigate staff shortages, some mental health facilities may find that they have too little expertise on staff at present to constitute even the most minimal of minimum YHCs. One facility, which was sufficiently thoughtful to keep careful records of allocation of staff time for a two-month period during the summer of 1982, found that the largest proportion of time any single staff member was devoting to the 0-19 group was less than fifteen percent, and most staff members were spending only two to three percent of their time with this age group. Such facilities may be forced to recruit experts in child and adolescent care before they can constitute even a minimum YHC. In these cases, hiring of the necessary experts must be a matter of the highest priority. The Secretariat Staff and the Local Committee concerned must actively aid and encourage any such facility and its hospital board in finding and employing the missing child/adolescent care specialists.

The fact that most of the new YHCs will not be able to provide the full range of services recommended below—given that they are utilizing current staff—is no reason not to create them. On the contrary, a YHC's existence, with its readily identified staff, budget, and (often) clear gaps in services will over time make more probable the recruitment of needed staff. As more professionals in the care and treatment of children and adolescents do become available, it may be that some staff initially delegated to the YHC may choose to return to the parent mental health facility.

Who is to direct the YHC? Initially, the YHC will exist only as an off-shoot of an existing mental health facility, but an off-shoot with a definite staff and budget. Its head ideally will be a senior-level professional, one at the doctoral level (M.D. or Ph.D.) and with at least several years of experience. In practice, many facilities will be headed by whichever staff member has the most experience, professional training, and interest in administration.

Administration

The head of the "minimum" YHC will in most cases serve under the "parent" hospital's administrator and Board of Directors and, initially, under the "parent" mental health facility's director. It is here that the educational intervention of the Secretariat Staff and the Local Committees will be crucial. Hospital boards must be informed about the need to create a YHC. Administrators must be convinced that any increase in the YHC's non-portable budget is not being made at the expense of adult services. These tasks are delicate in nature and the possibility of tension and even conflict between YHC staff and its head on the one hand and the parent facility and its hospital administration and board on the other is apparent. But the existence of a Youth Secretariat—of a cabinet level committee and of an informed Staff to report to that committee—provides machinery to resolve whatever difficulties may arise.

Location

Initially, the "home base" of the YHC necessarily must be the parent mental health facility. That, after all, is where the telephones, files, and secretaries will be. But the YHC staff need not spend the major portion of its time at this base. Schools, (other) hospitals, social service agencies, day care centres, and multi-service centres are the natural loci for YHCs to deliver services (as was mentioned previously) because their potential clients/ patients are already there. Each location has advantages and disadvantages which must be weighed by the YHC staff, with the advice of the Local Committee.

Schools, for example, have the advantage of the young people already being there, but being seen at a school-based YHC might turn out to be as stigmatizing as a visit to the adult mental health facility unless precautions are taken (e.g., providing physical health examinations or other functions at the same place and time). Another disadvantage associated with schools involves school districts that have neglected to provide school psychologists and other special services (see discussion below) and so may be tempted to use the YHC staff in an inappropriate manner. Social service agencies also have advantages and disadvantages. Any social service agency has its own type of stigma and is likely to lack the space for a YHC to meet; but, since many social service clients are children and adolescents, such an agency may nevertheless be a useful locale. Multi-service centres are perhaps ideal, in many respects, though there may be rental costs involved. A hospital can be a convenient site, but the YHC services should be dispensed from space seperate from the hospital's adult psychiatric services. Whatever the locale(s) selected, the Local Committee should encourage community agencies to provide space at little or no charge to the parent mental health facility.

Growing a YHC

If a minimum YHC is successful it will gradually increase its range of services and staff. As this happens, its autonomy must increase. The Local

Committee and the Secretariat Staff should determine at what point a particular YHC is ready to move from its "minimum" status. Such movement would be reflected by a home base of its own apart from the original mental health facility, one where telephones could be answered, files kept, and many services delivered. At this point, the other locations used by the YHC would in effect become satellite clinics, visited on a regular schedule. As many of these as possible would eventually themselves grow into YHC branches by the permanent stationing at them of a staff member. The advantages of such a permanent staff member in an area are considerable. Rather than being a visitor without roots in the community, the YHC branch office becomes a dependable service, ready to serve in an emergency.

A mature YHC should have its own advisory committee, separate from the advisory committee of the adult-oriented mental health centre. Either the Local committee itself or a subgroup of the Local Committee should wherever possible constitute the YHC's advisory committee. That advisory group must include both mental health professionals and interested laymen.

An expanding YHC in a populous area would have need of expanding facilities. Such facilities would, in line with the recommendations made in chapter V, be planned by the Local Committee and involve close cooperation and at times collaboration with other agencies in the region. These YHC facilities might include a day programme for children and adolescents (presumably with the Department of Social Services taking a major responsibility), therapeutic group homes, and therapeutic foster homes.

As the YHC grows it should increasingly emphasize the "health" component in its name. Even where a child psychiatrist is available, a pediatrician should be a regular or contractual member of the staff, providing comprehensive health examinations for most clients/patients. Ties with the community health nurses should grow and, by utilizing them, the YHC would participate in preventive medicine and primary prevention programs. When possible, experts in child/adolescent nutrition, speech therapy, and other aspects of health should be encouraged to become either part-time staff members or in some way associated with and available to the YHC. The emphasis on "mental" health will remain but not the Cartesian notion that mental health can somehow be separated from that of the body. A mature YHC should be holistic in its approach, serving the entire child and adolescent and not just one aspect of their being.

Recruitment of qualified staff will be a perpetual problem, as was discussed in chapter II. The Secretariat Staff should be of considerable aid, here, charged as it is with helping to recruit and to centralize recruitment, and with advising as to minimum qualifications. The key components of staff qualifications must be academic training coupled with clinical experience with young people. For example, doctoral-level child psychologists with either clinical experience or a one-year internship or practicum (which provide similar experience) are needed. But a psychologist at the Master's level who will be the sole member of that profession at a YHC should be recruited only with the understanding that he/she will be joined by a doctoral-level psychologist as soon as possible rather than (as currently tends to happen in the adult mental health facilities) the Master's-level psychologist taking the place of one with higher qualification.

In similar fashion, psychiatric and other nurses will be invaluable, provided they have special training and expertise with young people. MSW social workers are vital but only if their training and experience specifically include clinical and counseling work with children, adolescents and families (as opposed to training in community development, for example). Occupational therapists represent an under-utilized resource and, given the recent creation of a program with a strong child-oriented component in that field at Dalhousie University, the Secretariat Staff should consider recommending members of this profession as future YHC staff.

How large a staff would be enough for a YHC? Formulas exist which calculate a particular ratio of physicians and specialists to so many thousands of population but this Study embraces none. Given estimates as high as twenty-five percent of the population requiring mental health services, given continent-wide staff shortages, and given the high priority this Study recommends for services for young people, it would be unrealistic at this point to be concerned about future excessive growth. Moreover, formula-type ways of assessing need for mental health specialists for children and adolescents fail to reflect the following factors which must be taken into account by Local Committees, the YHC itself, Secretariat Staff and the Department of Health in judging need for additional staff: (a) extent to which schools, social service agencies, clergymen, and family physicians are already providing young people with mental health services; (b) proportion of time YHC staff is spending in providing direct treatment services as opposed to other activities; (c) presence of residential and other facilities with high-need populations in the catchment area (training schools, group homes, day care centres, the Nova Scotia school for Boys and the Nova Scotia school for Girls); d) current number of referrals being received. Given the almost unlimited potential demand, any YHC which is not receiving as many referrals as it can cope with is suffering from problems which must be analysed before staff is enlarged. Secretariat Staff and the Local Committee will be expected to analyze the nature of the problem and make appropriate recommendations.

Relationship with Adult Mental Health Facility

Though the YHC must be clearly identified as a separate and distinct unit, it must retain close links with the mental health facility from which it has "budded off". There is little point to solving the problem of fragmentation among agencies serving young people only to fragment mental health services to families. This Study recommends segregation of mental health services for young people not as an end in itself but as a means of developing these services for children and adolescents in parts of the Province where they have failed to develop. Thus, regardless of how autonomous the YHC becomes, there must be regularly scheduled formal and informal meetings between adult mental health facility and YHC staff. Some YHC staff, particularly those concerned with older adolescents, will find it useful to maintain a part-time appointment at the adult unit so as to provide continuity of care as their long-term patients/clients grow older. Practitioners of family therapy will certainly need to be on the staffs of both facilities, since their work necessarily includes both children and their parents. Total separation between YHC and adult facility staff and treatment programs, therefore, will never be a desirable goal.

Implementing the Medium and Long-Term Goals

While many YHCs will tend to evolve over time into the mature and autonomous facilities described above, the Youth Secretariat should plan to have one to two mature YHCs functioning within two to five years. Their location will be decided by the Youth Secretariat on the advice of its Staff, which will take into account local population base, degree of community support (as evidenced by an active Local Committee), availability of appropriate staff and physical facilities, and level of financial resources needed. The process of developing the minimum YHCs will give Staff the opportunity to evaluate which regions are appropriate candidates for more mature facilities for children and adolescents. Thus, the first step in implementing both the long-term and medium-term goals for the YHCs is to implement the short-term plan of "hiving off" existing mental health services for young people into distinct minimum YHCs.

What Minimum Treatment and Diagnostic Services Should the YHC Offer?

We cannot offer everything to everyone. As chapter VII makes clear, priorities are always required when potential services and demand are almost without limit. The list below represents a consensus among mental health professionals consulted about the minimum range of diagnostic and treatment services which every YHC should offer. The list will disappoint many, for it excludes courses in parenting, for example, or special services for children suffering from hearing loss and other handicaps. But even minimal as the list is, not all the services it includes are readily available in much of the Province. Many YHCs will need to build toward them.

Assessment and diagnostic capabilities:

1. Assessment and diagnosis of major psychiatric diagnostic categories.
2. Assessment and diagnosis of developmental problems.
3. Assessment of risk of danger to self and others.

Treatment capabilities:

1. Individual, group, marital and family therapy.
2. Behavior/social learning and child management therapies.
3. Ability to monitor medication prescribed as part of a treatment plan designed in consultation with another facility (e.g., the I.W.K.H. or N.S.H.).

Treatment planning and consultative capabilities:

1. Leadership in short and long-term treatment planning.
2. Leadership in rehabilitation planning.
3. Leadership in involving other agencies in treatment and rehabilitation planning.

Note that the range of assessment/diagnostic skills should be greater that the treatment capability. YHC staff may not be able to treat every type of problem but they must be able to recognize when a particular case requires referral elsewhere. For example, childhood autism is a grave but fortunately rare condition, requiring a long-term and difficult course of treatment. It would be unrealistic to expect a YHC to be able to provide the full range of therapies needed to treat autism, but the YHC staff must at least be able to recognize this condition or its possibility and so refer the patient to an appropriate facility for assessment. It should be able to consult with the facility preparing the treatment plan, and to provide a majority of the needed treatment (even though it could not provide the full range of treatment itself or without aid would be unable to develop the treatment plan, and to provide a majority of the needed treatment (even though it could not provide the full range of treatment itself or without aid would be unable to develop the treatment plan). Note that the facility providing the consultation must collaborate with the local YHC in developing the treatment plan, rather than providing one the local mental health or social service/school facilities are unable to implement.

Finally, the problems of a young person and his/her family may involve several agencies. Inter-agency coordination is one of the "mandated responsibilities" of the YHC and is discussed below. Here it need only be noted that such coordination requires skills and training which must be possessed by YHC staff.

The actual capabilities emphasized by the staff of any one YHC will depend on the particular needs of the region in which it is located. In the absence of epidemiological data, the YHC must determine needs on the basis of discussion with the regional Health Unit and the members of the Local Committee. Care should be taken that the capabilities emphasized by a particular YHC reflect the particular needs of its region.

The YHC, The Local Committee, and The Health/Education/Social Service Communities

The YHC is one component in the network of services needed by our young people. "Network" implies links and mesh: the YHC diagnostic and treatment services must not stand alone. The problems of young people tend to be multiple and to span agencies (as we saw in chapter II) and so must the solutions.

The Health Community and The YHC

The YHC is itself a health agency with ready access to physician time. As has been discussed, the YHC will place considerable emphasis on physical as well as mental health. Every young person seen at YHC should have a comprehensive health examination, preferably from a pediatrician. The examination need not precede a client/patient's first appointment at the YHC—young people need to be seen quickly and to delay a first appointment until a physical examination can be scheduled would be to defeat one of the reasons for having a YHC. Indeed, the examination may not take place at all if clinical judgement suggests that, for a particular individual, insisting on it would endanger the success of any therapy (perhaps by causing the young person to withdraw). But every child and adolescent seen at a YHC should, when at all possible, have a thorough health examination, including the taking of a medical history and a pyschological assessment.

A health examination is strongly recommended not in the name of medical hegemony but in the name of holism. The YHC is to be responsible for the whole child or adolescent, not just for one part. We know that the linkages between physical illness and mental state are always close. The chronically physically ill, for example, are at high risk of mental illness, while a substantial portion of the family practitioner's practice is actually more psychiatric than physical (Bailey et al. 1978). The isolated and lonely are more likely than others to suffer physical problems to the point of being more likely to die than those better integrated into society (Berkman and Syme 1979:186-204.)

The YHC cannot simply limit itself to an individual's "mental health" and be effective. It must attend simultaneously to the young person's psychological state, social situation and relations, and to his/her physical health. Hence, the pediatrician as well as the child psychiatrist, along with the social worker and psychologist, must work together at the YHC. No one profession merits automatic primacy. In one case, the family therapist social worker may be the principal therapist, while the physician becomes "ancillary personnel" limited to merely prescribing vitamins to correct the results of a poor diet; in another case, the problem may require the child psychiatrist to deal with an acutely psychotic child while the social worker (or other staff member) counsels the family on how to cope with living with this kind of illness. Cases in which a client/patient and his or her family have contact with only a single staff member should be rare.

If the various professions of the YHC staff must learn to cooperate with each other, they must also cooperate with the medical community at large, the family physicians in particular. From an entirely practical perspective, the YHCs will lack manpower--in almost any community, there will be more family physicians available than YHC staff members. Involving the family physician in the treatment plan wherever possible relieves some of the burden from the YHC staff. It may also give the family physician an opportunity to acquaint himself-herself with the skills and knowledge of the YHC staff and thus learn not only about their capabilities but also permit him/her to keep abreast of continuing developments in the diagnosis and treatment of the problems of young people. Since (as we have seen) a substantial portion of the practice of most family practitioners and pediatricians involves behavioral/emotional problems, this last aspect is quite important.

If a young person's designated family physician made the original referral then a report should as a matter of course be returned to that physician, who should be consulted about, and when appropriate, asked to participate in the treatment plan. Where the family physician has not made the referral, he/she should, with the consent of the patient/client and the written consent of the parents, be treated exactly as if he/she had made it.

The Educational Community

The YHC must maintain the closest possible ties with the school system, including delivering some of its services in the schools themselves. It is highly appropriate for a school district to lend facilities to a YHC. For group therapy in rural areas in particular, the school (when feasible) may be the most convenient location at which to conduct therapy. However, since there may be some stigma problems attached to delivering mental health services in schools, the YHC should either combine mental health with physical health care (e.g., have the pediatrician and community health nurse present, along with mental health staff) or else have an alternative location available for students who do not wish to utilize YHC services at school.

YHC staff should have special expertise in the area of school problems and be prepared to advise parents and children as to ways of coping with such difficulties. The YHC should also, as a matter of the highest priority, be prepared to provide back-up expertise and support to the special education and guidance departments of the school districts that must provide routine services such as intelligence and aptitude testing and the initial assessment and remediation of school problems (including learning disabilities).

School psychological services in general, and learning disabilities in particular, are a matter of current interest and controversy. In some parts of the Province there has been (and in one case, still is) a tradition of the community mental health centre providing routine psychological services (such as intelligence testing and other ability assessments) to the school system. In the Metro area, and occasionally elsewhere, the school districts do have considerable psychological and social work expertise available in their special services departments, but in much of the Province this is not so. Mental health facilities, in such areas, often feel themselves unfairly put upon in that the schools may demand services of them which the facilities feel the schools themselves should provide.

The important issue is not whether school problems should or should not be a concern of the Department of Health versus the Department of Education--we as taxpayers will pay for these services in any event and so need not find such jurisdictional questions to be of great import. The substantive issue is who is best qualified to provide school services, a school agency based in the schools themselves in daily contact with teachers and pupils and concerned primarily with matters affecting education, or a facility which may at times visit the schools but has as its chief priority mental health and illness? Until the 1981-82 amalgamation of school boards into larger districts (following the recommendations of the Walker Commission Report on Educational Finances), school boards could often legitimately complain that they were too small to maintain psychological and other special service departments. With amalgamation into much larger units, and with the provision by the Department of Education of a per student grant for special services, no school district today can make that argument. The school district is itself therefore in the best position to provide the special services it requires.

Some individuals and organizations interviewed felt strongly that many children suffer from undiagnosed "learning disabilities", by which they meant school failure resulting from suspected neurological problems. Instead of being properly diagnosed as "learning disabled", it was accused, such children had been labelled "dumb" and made to suffer a drop in self-esteem, perhaps developing compensatory behaviors leading to his/her leaving school early or even adopting a criminal life-style. Others interviewed, however, argued that many of the "learning disabled" children were merely being so labelled by parents who, refusing to accept their offspring's imperfections (or their own), wanted a medical explanation for failure. It is clear that there are major difficulties in identifying and defining learning disabilities, as shown by a recent Ontario study (MacIntyre and Agad 1980) (see chapter III for additional discussion).

It would seem wise for schools and the YHCs to stress not learning disabilities per se but school failure in general, to concentrate on systematically identifying pupils experiencing difficulty for whatever reason, and then to strive to provide appropriate remediation and treatment programs. To a considerable extent, this is the stance of a major British study of learning disabilities (Warnock et al. 1978). Closer to home, a 1981 Nova Scotia Department of Education handbook on learning disabilities (Learning Disabilities: A Supplementary Document for Teachers and Administrators, Curriculum Development Supplementary Document No. 34) places a similar stress on identification and remediation efforts.

The Secretariat staff must aid the YHCs in monitoring the remedial programmes available throughout the province and in identifying, with the help of the school and the I.W.K. Hospital, those pupils for whom no appropriate programme exists. Staff must then either recommend the creation of new programs for the learning disabled or else identify schools and/or treatment centres in other jurisdictions already providing them, and make appropriate recommendations to the Secretariat.

Along with monitoring the appropriateness of special education programmes for those using them, the YHCs, the schools, Secretariat staff and Local Committees must seek for gaps in services. For example, one mental health professional complained that a particular facility, while it did indeed provide special education, did not accept pupils who had any degree of emotional disturbance. Thus, there was a substantial gap left in that those unfortunate enough to be both emotionally disturbed and learning disabled were not being served in that region. Similar lacunae are likely to exist in a number of areas.

The initial responsibility for identification and remediation of children experiencing school problems must remain with the schools. But while the schools may be in the best position to identify a child with a problem, they often need support.

Let us take the not unusual example of a child whose school failure is rooted in family problems. Having identified the problem, the school system must now refer to the local YHC. The YHC, in turn, may or may not need help from other facilities, including the I.W.K. Hospital. These health facilities, in consultation with the school, must now develop an appropriate—and locally implementable—treatment plan. For example, the YHC may find it necessary to provide family therapy, while the school develops a remedial education program. The point is that both YHC and school must collaborate in helping the child. Neither may ever act as if the problem were solely the responsibility of the other.[3]

Or let us take the example of a child with impaired hearing. It may be the school, the family physician, or the regional Health Unit which first discovers the child's handicap. The YHC, the adult mental health facility, or the school must provide counselling for the child's parents (who may find it difficult to accept their offspring's disadvantage and, in any event, will need practical advice on how to cope).[4] If the child requires counselling or other treatment, the YHC must provide it or, should it have no staff member with the appropriate skills, either arrange for a qualified person to visit or else refer the child elsewhere. In all cases, the YHC must ensure that the school is aware of the problem. The child remains a shared responsibility of all agencies involved.

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[3] Many complaints were received, throughout the Province, of facilities acting as if in making a referral they had washed their hands of a troubled young person.

[4] If it is not clear whose responsibility such counselling is then the matter must be referred to the Local Committee.

Urging cooperation and shared responsibility between schools and mental health facilities is, however, insufficient. Such pious recommendations are pointless in the absence of administrative organization and social processes which make such sharing routine. Much of the responsibility for ensuring that cooperation does indeed take place belongs to the YHC, Secretariat Staff, and the Local Committees. These must educate both parents and district school boards, for example, to understand that they have cause for complaint if a single pupil is expelled from school without first having been seen by that school system's special services and guidance departments, and then by the YHC. In similar fashion, should the police detain a juvenile offender and find that, regardless of the offense, the young person was having school problems, then the police should as a matter of routine check to see if the school or the YHC was providing special services.

What if the answer in such a case were negative? Or suppose the YHC, upon receiving a referral from a physician about a child whose school performance has been affected, finds that the school system has failed to act? Or perhaps it is the physician who finds that the YHC has seen a child only once and then only after a long delay, even though the physician is convinced that the child urgently needed attention? The Local Committee must be the forum for investigating such complaints.

The goals of bringing a matter to the attention of the Local Committee are: a) first, to help the particular child or adolescent involved; b) then to understand how the system is operating or failing to operate from the perspective of an actual young person; c) and finally to learn how to prevent the problem from recurring. The goal is not to point a finger at a particular agency or facility: making a scapegoat of any one part of the network of services is a good way to destroy that network.

For actual, working cooperation to develop among agencies and facilities--rather than simply its appearance--it is necessary that personnel develop a sense of shared responsibility for the well-being of the community's children.

Rotation of personnel from school to a YHC and back (with a stop at a child welfare agency along the way) would help to develop this sense of belonging to a system of services and not just to one component. So too would shared appointments for some professionals, including speech therapists and occupational therapists, whose skills are at once both education and health services.

The YHC and the Community Health Units

The community health nurses are Nova Scotia's preventive medicine specialists, spending (in 1980) 47.5% of their time in home visits and another 9.7% visiting schools. The one hundred and fifty-four community health nurses and thirty-eight certified nursing assistants (again, as of 1980) provide expectant mothers with information on prenatal care, nutrition, life-style and child development, and also help to identify mothers who may be at risk during delivery. During the post-natal and general infant home visiting during the first year of life, they provide health supervision of infants and identify those who may be at risk for disease.

In addition to the home visit programs, the community health nurses are responsible for mental health and psychiatric follow-up visits for former patients and for providing "health counselling on psychological and emotional development of children and adults to prevent mental illness" (from material supplied by Ms. Edna Walsh, RN, M.Ed., Director of Community Health Nursing, Department of Health). The community health nurses also provide health supervision and consultation services to schools, and (in the Western Health Unit consisting of Digby, Yarmouth and Shelburne countries) do pre-school screening (though their emphasis is on screening for physical rather than psychological/psychiatric problems).

Community health nurses interviewed, in many parts of the Province, expressed at once a great willingness to cooperate actively with mental health facility staff and a sense of disappointment in their not being made use of as effectively as they would wish. The presence of the position of "community mental health nurse" in most psychiatric facilities mitigated the lack of coordination and cooperation between community health nurses and psychiatric facilities only to a limited extent.

In a few cases, agencies complained that while the community health nurses themselves were anxious to work with them, the nurses' own supervisors would at times oppose this cooperation. Should such difficulties arise in the future, it will be the responsibility of Secretariat Staff members to discuss the problem with all parties concerned and, if necessary, to make appropriate recommendations to the Secretariat. It is likely that some expansion of the community health units will eventually be necessary if the nurses are to be able to cooperate fully with the YHCs.

As will be discussed shortly (under "mandated responsibilities"), the YHC staff must fully cooperate with the community health nurses in conducting long-term monitoring of "high risk" individuals and families and in follow-up and after-care visits. There are simply too few YHC staff and too much need for direct treatment services to permit the YHC's personnel to devote a large proportion of their time to home visiting and "prevention" activities (as was discussed in chapter III). This is the job of the community health nurses.

The YHC and Social Service Agencies

In much of the Province, social service child welfare workers expressed anger toward mental health facility staff. The most common complaint was that wards referred for assessment were returned with the social history slightly restated but no new information, insight, or treatment or case management plan. In some cases the problem was one of unrealistic expectation on the part of social service workers but in others the difficulty was caused by the mental health facility's lack of expertise in children and adolescents. In general, mental health staff were only occasionally aware of the feelings of social service personnel.

Mental health personnel frequently are unaware of the requirements of social service staff. When a special protection or juvenile protection worker requests advice or a mental health assessment for a young person what they are usually seeking is information to guide them in deciding what to do next.[5] Social service workers are decision makers and frequently must decide whether to take a child into care or into care and custody, or what to recommend to a family court judge. Mental health staff tend to be analytical rather that action-oriented, so that social service personnel complain that the former's reports and consultations are not useful, meaning that they do not point to a course of action.

Another problem between social service and mental health staff has to do with selectivity. Mental health staff--like other health personnel--provide treatment only where they feel treatment is warranted. Moreover, consent of parent or guardian is legally required for treatment of children. On the other hand, social service personnel administering the Children's Services Act not only have no legal requirement for consent but in some cases are required to take action regardless of their personal judgement. Social service agencies are, after all, in some respects law enforcement agencies. However, social service child welfare workers tend to interpret the apparent selectivity of mental health staff as "picking and choosing" clients/patients, leaving the social workers to deal unaided with the most troubled and troublesome young people.

If there has not been frequent and friendly communication between social service and mental health staff it is easy for the social service worker to feel victimized. But where mental health and social service agencies do have facilities close enough to one another for frequent informal meetings to occur, tension between the two is largely absent and is often replaced by good feeling. Hence, a simple recommendation: if two agencies are not close enough to share coffee breaks (perhaps with a common lounge), there should be regularly scheduled meetings set aside for informal consultation (e.g., every second

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[5] The "juvenile protection worker" was formerly known as the "juvenile probation officer". His/her duties have to do with young people who may be juvenile offenders. The "special protection worker" has responsibility for children who may be at risk of abuse or neglect.

Friday afternoon). Coffee and doughnuts can communicate more effectively than memoranda.[6]

A second recommendation is that YHC staff members periodically be seconded to child welfare agencies in order to learn first-hand of the needs of their colleagues.

A third recommendation concerns the juvenile protection (juvenile probation) workers. As will be discussed in chapter VIII, the Atlantic Child Guidance Centre is planning a court clinic. It is here recommended that, as YHCs mature, at least one staff member from each be trained in the purposes and duties of that court clinic, and thereafter provide to the extent possible court clinic services to the local family court. These services would include, of course, the pyschiatric/psychological assessments the juvenile protection workers at times require.

A fourth recommendation dealing with the relationship between the YHC and social service personnel concerns child abuse. While aiding its victims is a responsibility of child welfare personnel, abused children often suffer from emotional difficulties and require therapy as soon as possible (Kinard 1980:451). There must be the closest cooperation between the YHC and social welfare staff in cases of real or suspected child abuse. YHC staff must respond immediately to emergency requests for consultation and assessment from child welfare workers in cases of possible child abuse.

A fifth recommendation deals with an important source of tension between social service and mental health personnel: parental cooperation. Mental health staff frequently demand substantial cooperation from parents or foster parents before agreeing to provide treatment to a young person. However, social service workers often point out that if the parents or foster parents were indeed capable of such substantial cooperation then the child or adolescent probably would not have been in need of treatment in the first place! And once again, a mental health facility's withdrawal, for any reason, often leaves the problem in the hands of the social service worker. This Study therefore recommends that YHCs make every effort to provide young people with help, even where full parental or foster parental cooperation is lacking.[7] While many mental health professionals argued strongly that there is no point to therapy if parents or parent surrogates are not actively involved, a major British study (Kolvin et al. 1981:326), evaluating the effectiveness for young people of different treatment techniques, found that the importance of parental cooperation in therapy (as opposed to simple parental consent) may be somewhat over-rated by mental health facilities:

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[6] Chapter XI will include a recommendation for sharing training and continuing education for social service and mental health workers, with the aim of breaking down barriers between the two groups.

> Often treatment has been denied to children because of what it [a mental health facility] considered to be intransigent social and personal family problems and also poor motivation or lack of organization on the part of the family in getting to the clinic. The consistency of our findings emphasizes the importance of treatment of the children themselves with parental contact taking a secondary but probably important place. (Emphasis Kolvin's.)

Treatment took place in the schools in the Kolvin study. No doubt such treatment is less convenient for staff than treatment at the clinic; no doubt, too, that treatment of children of unmotivated or uncooperative parents is more difficult than treatment of those whose parents are ready to cooperate with mental health staff; and no doubt that some partisans of family therapy will be reluctant to use other forms of treatment: but the policy of not treating the children of the "unmotivated", of which social service personnel frequently complained, does not appear to have scientific justification.

Even where there are no parents or where parents are uncooperative, the YHC staff must make every effort to treat children needing their help and not, when these children happen to be wards, simply refer them back to the child to the child welfare worker. But the child welfare worker, on the other hand, must actively cooperate with the YHC by assuring the young person's foster parents that their help in therapy is both necessary and appreciated. The importance of child welfare/YHC cooperation is underscored by Jacobson et al.'s (1980) finding that children using psychiatric services provided by a department of health are also likely to use non-psychiatric social services.

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[7] This issue is returned to in chapter VIII. It should be noted that there are degrees of cooperation. The minimum is legal consent from parent or guardian, without which treatment is not legally possible.

In general, YHC staff should provide the same kind of "back up" for social service personnel as was already recommended they provide for the school. For example, YHC staff should be ready to counsel foster and adoptive parents when their charges perplex them, as well as being ready to advise the social service workers themselves. In cases in which emergency decissions must be made, e.g., child abuse, the YHC staff must be ready to help the special protection worker to assess both child and situation immediately and make the appropriate recommendation. When the social service worker must decide whether to apprehend or not apprehend a child, what is needed is not an appointment for six weeks later but immediate access to the YHC staff. (The emergency and after-hours services of the YHC, discussed below under the heading of "mandated services", will make it easier for social service personnel to have ready access to mental health staff.)

In Nova Scotia, the Department of Social Services has long-term responsibility for most of the physically and mentally handicapped, and for day care centres. The earlier discussion of "staffing" noted that YHC staff size and skills should reflect the needs of social service residential and other facilities in its catchment area requiring mental health "back up". Training centres for the mentally retarded merit special attention here, for the mentally retarded constitute a "high risk" group, that is, a population at high risk of developing mental illness. This Study recommends that each social service facility (including residential facilities) requiring mental health "back up" and serving the 0-19 age group enter a formal association with a YHC, which will be expected to provide routinely both assessment and treatment for that facility's children and adolescents, as well as counselling and advice both for the young people's parents and for the facility's staff. The programs offered by training centres, day care centres, and other social service facilities are properly the concern of the Local Committee and Youth Health Centre staff. (The fact that the YHC staff is likely to be represented on the Local Committee should aid communication between social service and mental health facilities so that the latter can provide proper support for the former.)

Mandated Responsibilities of the Youth Health Centre

Three of the problems discussed in chapter II were lack of coordination among agencies providing services to young people, lack of long-term responsibility for troubled children and adolescents, and lack of emergency and after-hours mental health care for young people. These responsibilities belong to the Youth Health Centre.

Coordination

Short of having a single agency responsible for all health and social services for young people, the only way to stop the "ping-pong" phenomenon in which a child or adolescent is bounced back and forth among agencies is to have one agency which automatically serves as coordinator. This is a difficult job, one requiring special training. Because the problems of young people are so often multiple in nature, a child or adolescent may be being seen by a school special services department, a mental health agency, a drug dependency agency, a child welfare worker, a juvenile protection worker, and a family physician, either all at once or over a period of several years. At present, there is a strong tendency for each agency to know little or nothing about the activities of the others.

Coordination in such cases is difficult because each agency has no automatic way of knowing what other services the child or adolescent is receiving. If parents or child are unable or unwilling to provide this information, the YHC will not immediately know. The YHC must have sufficient informal contact with other agencies to be aware in general of their activities and to know what questions to ask of whom.

In practice, "coordination" means keeping all agencies aware of what others are doing. The coordinator requires understanding of the vocabulary and perspectives of each agency. Informal telephone and in-person discussion, along with (when needed) formal case conferences can serve the purpose of coordination, providing there is someone with the responsibility to make the telephone calls and call the conferences. That person must be a YHC staff member.

A major impediment to such coordination and communication is legal in nature. The Hospitals' Act does not permit the dissemination of health information to agencies other than hospitals and the family physician without the written consent of the patient or (for juveniles) a patient's parents. Thus, the YHC cannot as a matter of course inform a school or a social service agency of its findings, even though the latter two agencies can indeed transmit their information to the YHC (or other health facility). For example, if a child's parents do not wish the schools to know that their child is seeing a mental health professional then the YHC cannot convey that information to the child's school—even though the YHC staff may feel that the active cooperation of the school is essential for the child's treatment.

The Hospitals' Act requires sufficient change to permit the YHC coordinator to do his/her work. For example, if a single computer system (or different systems with compatible programming) recorded all contacts with particular children/adolescents and their families, then it would be quite simple for a YHC coordinator to determine which agency has already had experience with any child/adolescent and so be able to ask to share their knowledge. From the point of view of research purposes, too, it would be invaluable to determine the extent to which present services are being utilized by a small number of multiple-problem, multiple-agency users, as opposed to individuals seen by just one agency in the system. Most school districts already have computers which would be more than adequate for this simple purpose. Unfortunately, to permit them to be used for coordination of services would probably require an amendment to the Hospitals' act and serious thought about the matter of confidentiality.

This Study recommends that a committee, consisting of at least one member from the Department of Health, from the Department of Social Services, and from the Department of the Attorney General, be struck to determine whether and how the Hospitals' Act and other relevant legislation should be altered to permit more full cooperation among agencies serving young people.

Long-Term Responsibility and Follow-Up

Table 21 in chapter IV showed that a substantial proportion of 0-19 mental health outpatients in 1980 had previously been patients/clients at a mental health facility. These data support the observation frequently made by mental health staff in interview that a substantial portion of their caseloads were chronic patients. Presumably, many of these individuals were also receiving services from other agencies (in addition to mental health facilities). Presumably, too, many "closed cases" of mental health facilities would be reopened were there regular follow-up contacts (at present made in a relatively unsystematic manner by most facilities).

If chronic and multiple-problem cases require long-term monitoring, so do individuals and families in high risk catagories. This topic is dealt with at greater length in chapter III ("prevention"). Here, it is important only to note that the children of the mentally ill, low birth-weight infants, the mentally retarded, the chronically physically ill and handicapped, and some others are at considerably greater risk than the average young person for mental illness. Monitoring of children and adolescents in "high risk" categories, along with chronic patients, must be a mandated responsibility of the YHC.

This long-term monitoring function is the major prevention responsibility of the YHC, one which it must share with the community health units. The nurses of the community health unit must have primary responsibility for the regular home visits long-term monitoring requires, and for reporting their findings to the YHC. At present, mental health facilities depend on the former client or patient voluntarily returning. Unfortunately those most in need of aid are perhaps also most likely to fail to keep an appointment or respond to a telephone call. And at present, though most mental health facilities consider prevention to be one of their highest priorities, they appear to pay no particular attention to such high risk categories as low birth-weight infants. This Study recommends that the YHCs be given responsibility for long-term management of chronic mental health patients and for individuals in high risk categories. It further recommends that the actual mechanism for such monitoring involve home visits conducted primarily by the community health nurses.

This recommendation has several implications. (1) It means that the YHCs and/or the community health unit must have access to basic computer facilities so that a registry of high risk and former patient families can be maintained and regular lists of needed home visits can be generated in a systematic manner. (2) It implies that the number of community health nurses be increased in line with the increased duties here being given them (though their mandate already in part includes these duties). (3) It implies that YHC staff and community health nurses and their supervisors and unit directors be trained together to cooperate in monitoring and other prevention activities. In some cases, this will mean continuing education for YHC staff concerning the training and capabilities of community health nurses, and some additional training of the community health nurses themselves in what to look for in monitoring for mental illness or related problems (as well as in providing other, preventive services.) (4) Finally, it implies that the community health nurses, the child welfare workers, and the YHC staff collaborate closely in cases of suspected child abuse. (Community health nurses, after all, are specifically trained to identify child abuse.)

Implementing the Coordinating and Long-Term Monitoring Functions

A fully autonomous, mature YHC should have little difficulty in carrying out its mandated responsibilities to provide leadership in coordinating services of agencies to particular individuals and families and in cooperating with the community health unit in the long-term monitoring of former patients/clients and others statistically at high risk of mental illness. A minimum YHC, however, will not be able to perform these functions.

In most parts of the Province, the Local Committee must address the question of which agency or agencies in the region will best be able temporarily to discharge some of these mandated YHC responsibilities. Perhaps the adult mental health facility would wish to do so, or the local Health Unit. It is important that Secretariat Staff aid the Local Committees in ensuring that at least some systematic monitoring and coordinating of services takes place.

Emergency and After-Hours Services

A common complaint across the Province was that mental health staff were rarely available after hours or on weekends. Typically, only the psychiatrist member of the mental health staff would at times be available after hours since, as a physician, he or she could expect to be paid by MSI on the usual fee-for-services basis for work out of regular office hours. Other mental health staff members complained that any emergency work they did was the equivalent of a charitable donation. Consequently, they were reluctant to make frequent donations. In many areas, where the mental health services are dispensed by the psychiatry department of a local hospital, only ordinary emergency department medical services are available, the general practitioner on duty having the option of telephoning to a psychiatrist.

As the last of its mandated services, the YHC should have a staff member on call at all times. The YHC's non-portable budget should include compensation for all staff members (including but not limited to physicians) for out-of-hours work. The telephone number at which the on-call staff member could be reached would be left with all appropriate agencies, e.g., posted on the door of the YHC office itself, with the hospital emergency department, local police and clergy. In addition, YHCs should have automatic telephone answering systems so that after-hours callers will get the telephone number of whichever staff member happens to be "on call". The "on call" staff member would be to enlist any of his/her colleagues necessary. Thus, if police needed help in determining what disposition they should make of a young person behaving in an unusual manner in a public place, or if a social service worker needed help in assessing a child or a situation, or if a clergyman faced a suicidal adolescent, aid would be available on a twenty-four-hour basis.

The use of such emergency service would be reduced if the YHCs had regularly scheduled hours during some weekends and evenings. YHCs should not consider (as some now do) a parent's unreadiness to take off time from work as a sign of uncooperativeness. Rather, the YHC should accommodate itself to the schedules of young people and their parents.

Limitations of the Youth Health Centres

Even if all recommendations in this report concerning YHCs are implemented, we will still have troubled and unhappy children, adolescents, and families. Learning problems will continue to occur, teenagers will still run away from home, parents will have child management problems. Disorders that we now have little success in treating (e.g. conduct disorders, particularly those involving aggressivity) will not suddenly permit themselves to be "cured". The YHCs will go a long way towards reducing some of our problems of delivering needed services. They should make our interventions more successful. But the YHCs themselves will do little to change the causes of mental illness, let alone the causes of ordinary unhappiness and grief among troubled young people. The YHCs represent doing what we can, even while knowing that this will not be enough. Our expectations of the YHCs must be high, but not so high that we are waiting for magic.

Summary of Chapter VI, The "Youth Health Centre Model"

The Youth Health Centre (YHC) model refers to a flexible range of ways of organizing the delivery of mental and other health services to children and adolescents. The YHC model is not, however, recommended for the Halifax-Dartmouth metropolitan region.

I. Guiding Principles

A. Mental health facilities for young people must be kept physically, budgetarily and programmatically as separate as possible from those for adults. Stigma is part of the reason for this guideline, competition the other.

B. There must be no competition between mental health services for adults and those for children and adolescents. Competition here means budgetary competition, competition in terms of range of services to be available, and competition for staff time and appointments. In Nova Scotia, wherever these kinds of competition have been permitted to occur the young have been losers.

C. Mental health services for young people should be combined, wherever possible, with general health services.

II. Organizing Youth Health Centres

A. A portion of the psychiatric services of each non-Metro mental health facility must be dedicated to the 0-19 age group and made non-portable. That portion should initially reflect the proportion of a facility's out-patient efforts currently devoted to young people (as indicated by tables 9, 10 and 14 in chapter IV) and will be referred to as the "youth services budget".

B. A minimum YHC will be a clinic of an existing non-Metro mental health facility staffed by whichever current personnel have the most expertise in the problems of young people. It will provide a major portion of its services in settings physically distinct from the adult mental health agency. It will be financed by the youth services budget.

C. A maximum YHC is a facility physically and programmatically separate from an adult mental health service and staffed by child psychiatrists, psychologists, social workers, pediatricians, and other health and mental health personnel (such as speech therapists, occupational therapists, nurses, etc.). It should have its own advisory committee. It may include under its auspices related facilities and programs such as therapeutic group homes and day care and residential centres.

D. As a short-term goal, minimum YHCs should be created whenever there are existing mental health facilities. Since these will utilize current personnel and borrowed physical facilities, they can be organized immediately and at little cost.

E. As a medium-term goal, at least one or two maximum YHCs should be created as pilot projects.

F. As a long-term goal, there should be a maximum YHC in every part of the Province. To the extent that budget and staff shortages make it feasible, minimum YHCs should gradually be helped to grow into maximum YHCs.

G. The Youth Secretariat Staff is to play a major role in the initial organization and continuing encouragement of YHCs. (Aiding in recruitment of staff and organizing tours of traveling experts to relieve staff shortages are two ways in which it may do this.)

H. A YHC must retain close links with its parent mental health facility by, for example, cross-appointed staff members and regular meetings. Separate mental health facilities for young people are meant as a means of increasing services available to them rather than as an end in itself. Separation must not be carried to the point at which it is no longer possible to treat a family as a unit.

I. The YHCs must cooperate with other helping agencies in identifying and closing gaps in the network of services for young people. Here, the Local Committee structure and the Secretariat Staff will play a major role.

III. Less Major But Still Important Recommendations

A. YHC and child welfare staff must either share common coffee facilities or else schedule regular informal meetings to facilitate communication. Similar meetings with appropriate educational and other personnel are also to be encouraged.

B. YHC staff members should be periodically seconded to child welfare agencies and, where possible, educational systems in order to learn first-hand of the needs of their colleagues.

C. At least one member from each YHC is to be trained in the purposes and duties of court clinics in order to provide, to the extent possible, court clinic services to family courts and to juvenile protection (juvenile probation) workers. (The court clinic being planned by the Atlantic Child Guidance Centre should provide this training.)

D. There must be the closest cooperation between the YHC and child welfare staff in cases of actual or suspected child abuse.

E. Even where a young person has no parents or where the parents are uncooperative, the YHC staff must make every effort to treat children needing their help and not, when these children happen to be wards, simply refer them back to the child welfare worker.

F. Child welfare workers must, in cases of emergency, have immediate access to YHC staff.

G. Social service facilities requiring "back up" mental health services for age 0-19 individuals should be invited to establish a formal agreement with a YHC, which will then be expected to provide routinely both assessment and treatment services.

IV. Mandated YHC Responsibilities

A. Where a young person is being served by more than one facility or agency, the task of coordinating services belongs to the YHC.

B. In order to permit the YHC coordinator to accomplish his or her task free of possible legal restrictions, this Study recommends that a committee, consisting of at least one member from the Department of Health, from the Department of Social Services, from the Department of Education, and from the Department of the Attorney General, be struck to determine whether and how the Hospitals' Act and other relevant legislation should be altered to permit more full cooperation among agencies serving young people.

C. Monitoring of children and adolescents in "high risk" categories, along with monitoring of chronic patients, must be a mandated responsibility of the YHC.

D. The nurses of the Health Units must have primary responsibility for the regular home visits long-term monitoring requires, and for reporting their findings to the YHC.

E. Therefore: 1) each YHC must have access to basic computer facilities so that a registry of high risk and former patient families can be maintained and regular lists of home visits can be generated in a systematic manner; 2) the number of community health nurses may eventually need to be increased, in line with these new duties; 3) and YHC staff and community health nurses and their supervisors and Health Unit directors must be trained together to cooperate in monitoring and other prevention activities.

F. Given that most of the Province will not have maximum YHCs for some time, the Local Committee must address the question of which agency or agencies in each region will best be able to discharge temporarily some of these mandated YHC responsibilities.

G. A YHC must have a staff member on call at all times. All YHC staff members (and not just physicians) should be compensated for out-of-hours work.

H. YHCs should have regularly scheduled hours during some evenings and weekends.

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Chapter VII

PRIORITIES

No topic is quite so current, today, as is that of "priorities". Though often "setting priorities" is a euphemism for "deciding which programs we can cut", the reality is that without clear priorities we may achieve none of our goals.

"More"

Government studies on the problems of young people abound: There are reports on foster homes, on single-parent families, on the "impossible" child, on prevention, on court clinics, on every conceivable topic related to "psychiatric mental health services" for children and adolescents. The hundreds of recommendations resulting can be summarized in a single word: more. More services, and more services, from specially trained foster parents to better funding for volunteers, from respite centres for the parents of the handicapped to screening programs for preschoolers, from courses in stress management and parenting to better pre-natal and post-natal nutrition education, from more drug counselling for adolescents to more training for teachers in the problems young people have, for more residential treatment facilities, more crisis centers, more development clinics, more group homes and halfway houses, more child psychologists, more pediatric psychiatrists and neurologists, more social workers with expertise in counselling young people, more nurses skilled in the problems of the young, more occupational therapists. More.

Perhaps, during the sixties and the seventies, reports that said that we need "more" were adequate. The report writers of the past seem to have implicitly assumed that to indicate a need was somehow to generate the resources to meet that need. Such reports reflected an expectation of endless economic growth. Today, we are wiser and know we cannot have everything: we must decide what we need the most and what we may have to do without. In an era of limited resources, priorities become essential.

But priorities always were needed, in the mental health field. As Leighton (1982) points out, psychiatric epidemiological studies which found that anywhere from 10 percent to 25 percent of the adult population were in need of psychiatric help had an obvious but ignored implication: no government can afford to provide such services for so large a proportion of its population. One Million Children (p. 59) finds that perhaps 10 percent to 15 percent of children can be considered to be in need of mental health or related services. A more recent U.S. study (Sowder 1975) found that 2.7 percent of the 0-17 age population was severely disturbed, 16.8 percent less severely disturbed but in need of help and an additional 13 percent had problems severe enough to warrant referral to a mental health centre. So 19.5 percent of young Americans definitely need help and another 13 percent should probably get it. In Nova Scotia, in 1981, less than 2 percent of the 0-19 population were either inpatients or outpatients of a mental health facility (see chapter IV, table 31 for details and discussion). The U.S. study cited above found that only one third of children in need of mental health services were actually treated (p. 152). For Nova Scotia, there is no reason to believe that we are seeing even that proportion of those who would benefit from treatment. Until our society becomes so wealthy that all can be served, we must set priorities.

A study of Nova Scotia mental health facilities suggests that it is not need which determines utilization rate but government policy and availability of services (Boutelier 1981). This is so because the potential number of clients/patients for these services dwarfs their capacity. When the Atlantic Child Guidance Centre opened a branch in Sackville, in 1981, the number of young people served from that area shot up. Though Sackville is only a short distance from the Halifax and Dartmouth ACGC branches, that distance was obviously great enough to deter many potential users. Now, what would happen if we were to put a branch of ACGC in every county? Or five in every county? Can anyone doubt that they too would shortly be utilitized to capacity?

The demand for services, the cry for "more", is legitimate. But we cannot expand indefinitely. Indeed, given the state of our economy and the fact that the proportion of young people in our population is diminishing at a time when the proportion of older people is increasing, any vast expansion of services for young people seems quite unlikely. Badly needed, yes. But unlikely. Demand for children's and adolescents' mental health services ultimately is limited only by the anxiety of parents: Either we set our priorities deliberately or we will have them set for us when our governments run out of funds.

Setting priorities means that some services wanted and demanded by the public will not be provided. For example, in chapter VI it was recommended that the Youth Health Centres not provide intelligence testing for children simply on demand of parents where there is no apparent behavioral or performance problem. Many parents do demand such testing, however. They are in precisely the same position as are those who wish their children to receive an education in subjects not offered by the school system (religious education, for example). Private enterprise must step in where government falters. Registered psychologists and social workers can certainly engage in private practice. True, potential clients at the poverty level will not benefit from their services. But government can only try to provide the most necessary facilities—the rest we must provide for ourselves as individuals or do without.

Guidelines

The task of setting priorities for mental health and related services for children and adolescents becomes less complex if we follow these four guidelines:

1. Decisions concerning the range of treatment services to be available at a Youth Health Centre, as well as the types of clinicial expertise required, are to be made in the light of scientific research findings.

2. Decisions concerning the high-risk target populations to be provided with the combined preventive/research efforts discussed in chapter III are to be made in the light of the scientific literature.
3. Decisions concerning the budgetary priority of regional programs and facilities for children and adolescents (e.g., day care, residential treatment centres, etc.) are to be made by the Local Committee with the aid and advice of the Youth Secretariat Staff.
4. Services relating to the direct treatment of mental illness must be kept budgetarily separate from all other services to young people (taken from chapter III).

Discussion of Guideline 1: data-based decision-making

Guideline 4 requires no additional discussion, having been presented in chapter III. But the remaining guidelines do need explanation, particularly number 1: the need for research-based setting of priorities in treatment services offered by a Youth Health Centre.

Chapters III and IV discussed how Nova Scotia's mental health facilities show considerable variation in staffing, treatment options, and duration of treatment. Not scientific data but the background and educated guesses of a facility's staff appear to be the key factors in determining its treatment services and priorities. Rational, scientific decision-making concerning the professional staffing and skills a mental health facility requires, and the treatment options it should offer, demand various kinds of knowledge.

a) Epidemiological data on the incidence and prevalence within a facility's catchment area of the various mental disorders are needed for rational decision-making. Without such data, a facility's treatment priorities tend to be determined by the kinds of cases referred to it. Referral patterns reflect the referring agents' perceptions of the facility rather than necessarily being strongly related to the actual incidence of disorders. Without epidemiological data the possibility exists that some serious disorders may be coming to the attention of neither the referring agents nor the mental health facility, or else are seldom referred by the former to the latter. The frequency with which a particular diagnosis is made at a facility is not a valid indicator of the prevalence of that disorder within its catchment area.

b) Suppose we have epidemiological data: does this mean that the more common the disorder, the higher the priority the facility should give to making sure that it has the skills to treat it? Obviously not, no more than hospitals should give their highest priority to treating the common cold because it is common. But there is a tendency for mental health facilities to do the equivalent, to spend most of their effort on short-term, "band-aid" help for the many with problems of living rather than on the few with serious illness. The key word here is serious: along with the incidence of an illness, facilities must take into account the seriousness of the various mental disorders in making their staffing and skill decisions. Seriousness on the one hand and incidence on the other must be balanced against one another.

c) Rational decision making requires data on the treatability of each disorder. Here a process very similar to the economist's cost/benefit analysis must take place. There is little point in having the skills to treat a serious disorder, even if it is also a prevalent one, if the state-of-the-art is such that no known treatment is likely to be effective in the long-term. But treatability also has to do with the amount of staff time and effort required for a given degree of patient improvement. For example, some mental health professionals argue that conduct disorder is a malady which makes little cost-benefit sense to treat in a hospital setting. It is not very treatable, meaning that staff must invest much time and energy for little (if any) permanent improvement in the condition. Since it is very prevalent, however, facilities (particularly the Nova Scotia Hospital , as we shall see in chapter VIII) are under considerable pressure to give its treatment a high priority, at the expense of other, perhaps more treatable disorders.

d) Rational decision-making also requires data on what kinds of professionals treat what kinds of problems (or patients) most effectively (again, effectively in terms of the cost-benefit analysis discussed above). As chapter IV shows, there is a sort of division-of-labor among the various professionals represented in our mental health facilities; unfortunately, we have no data on the effectiveness of this division of labor. In a real sense, facilities hiring staff are in a poor position to know what they need.

e) Rational decision making requires that a facility know whether long-term or short-term treatment should be provided. Which type of intervention is likely to be more cost-effective? Once again, only research findings can answer this question.

An example of the kind of research needed for this kind of rational, cost-benefit approach to setting treatment and staffing priorities is that of Kolvin (1981). He and his collaborators argue (p. 331) that:

> Carefully controlled studies should point to the "best buy" in terms of developing services. The evidence that the administrator examines will include the cost and effectiveness of the programme, its ease of implementation, and the reaction of parents.

Their own work typifies the kind of "carefully controlled studies" for which they call. This research project, conducted in schools in London, England, examined a range of treatment options. The subjects were groups of 7-8 year olds and 11-12 year olds, pre-screened for signs of emotional disturbance but with the psychoses excluded. The investigators found that "the shorter term treatments (group therapies, play groups, and behavior modification) were seen to have had the best outcome" (p. 300). Not only were these techniques more successful in terms of therapeutic outcome than were others (such as having social workers and psychiatrists counsel parents and teachers), they were also less expensive: hence, they were found to be doubly cost-effective. With the younger age group, a "nurture approach" in which non-professional, part-time teacher's aids were trained to provide "the type of interaction characteristic of a healthy mother-child relationship, which includes warmth, interest and acceptance..." (p. 139) was also successful, suggesting that non-professionals may be quite effective as therapists under some circumstances. Kolvin and his collaborators conclude that short-term therapies can be cost effective, that non-professionals can at times succeed as therapists, and that direct contact with the children is more important than having contact with their parents.

The Kolvin project is presented as an example of the kind of research by which decision-making bodies should be guided. Doubtless, some will find imperfection in its procedures and conclusions, while its applicability to Nova Scotia is uncertain. Our Province is not London, and the Kolvin project was limited to only two age groups and four types of treatment, with the psychoses excluded in favor of children with conduct disorders and neuroses. But requiring that Secretariat Staff be familiar with the kind of careful, scientific research on cost-effectiveness represented by the Kolvin study, and that it be guided by such research in making recommendations concerning staffing and treatment regimes to Youth Health Centres and Local Committees, is certainly preferable to having such decisions made in any other manner.

Another research area with which Secretariat Staff must be familiar is that of "treatability". Kolvin (1981:13) and Rutter and Madge (1976:197) echo the consensus among child psychiatrists and psychologists that conduct or behavior disorders are much less likely to be treated successfully than are the neuroses. Behavior problems often lead to "life long behavior and personality disorders and, in addition, may be associated with deviance in subsequent generations" (Kolvin 1981:13). Child psychiatrists also believe that disorders involving hyper-aggressivity are rarely effectively treated once early childhood is past. In general, however, as Rutter and Madge (1976:197) indicate, "at the present time no reliable criteria are available to distinguish, in childhood, between disorders which prove transient and those which persist into adult life." [1]

If data on treatability and prognosis are imperfect, psychiatric epidemiological data pertaining to Nova Scotia's children and adolescents are non-existent.[2] Health personnel familiar with the Province believe that there are marked regional differences in the prevalence of some kinds of problems but no consensus on what these differences are appears to exist. The need for research data to help us to provide appropriate, regionally tailored treatment programs is obvious. Much psychiatric epidemiology in the past has concentrated on global figures of the rate of mental disorder. However, Murphy (1980) and others have argued that, for planning purposes, data on the incidence of specific disorders would be much more useful. Thus, what we need in Nova Scotia is not one more study to tell us that ten or fifteen percent of our young people have problems but what the specific problems are and how the different parts of the Province differ in epidemiological profile.

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[1] Earls (1980b) reminds us that the first goal of treatment is to relieve a child's suffering and not just prevent mental disorders in later life.

[2] For an overview of the field of child psychiatric epidemiology, see Earls (1980a).

Discussion of Guideline 2: High Risk Groups and Prevention

Chapter III analyzed the complexities of prevention and concluded that such prevention efforts should simultaneously be research projects in order that their effectiveness—or effects—be objectively evaluated. But which of the various high-risk groups discussed in chapter III should be the targets of prevention programs? Guideline 2 recommends that the choice of target groups be made on the basis of the research literature and further assumes that the Secretariat Staff will be familiar with this literature. Unfortunately, this literature is not presented in a cost-benefit framework, the framework in terms of which Secretariat Staff must set priorities. What are the likely financial and staff time costs of a project? What are the "opportunity costs", that is, what projects cannot be conducted if there is a commitment to this one? What indications are there that the targeted group will actually benefit? These are the questions Secretariat Staff must keep in mind as it reviews the literature.

An alternative to targeting a particular high-risk group is targeting a specific mental disorder. The two approaches are not mutually exclusive and it is both possible and perhaps advisable to follow both at once. A prevention program would be aimed at a particular group, one at risk for a specific mental disorder (or disorders). The outcome of the program would then be evaluated largely in terms of its effect (or lack of effect) on that particular disorder (or on those particular disorders).

But choosing specific disorders and populations cannot be a function solely of the Secretariat Staff. Prevention efforts must have the active support of the Local Committee (particularly as they are likely to require substantial inter-agency cooperation). The role of the Secretariat Staff should be to provide expert advice, here. The fact that the Secretariat Staff makes recommendations concerning funding to the Secretariat itself gives it substantial power--potentially, almost a veto power--but it does not have the power to mount a preventive program that is not strongly supported by the Local Committee.

Discussion of Guideline 3: Decision-Making is a Political Process

The preceding paragraph foreshadowed the point of this third guideline. Secretariat Staff provides expert advice. Its members keep up-to-date on the relevant scientific literature and follow closely events in other jurisdictions. They also strive to reach regional balance within the Province as a whole. But within each region the Local Committee (with the aid of Secretariat Staff) must set its own priorities on what services its young people need the most. It is clear that no region can be assured of getting every facility it may need, given that Nova Scotia enjoys more legitimate need for services than resources with which to provide them. But by obtaining a consensus on priorities, the Local Committee at least helps to ensure that local decisions are indeed made locally rather than only in Halifax.

Research data aids in the determination of priorities. For example, if a proposal is for respite care for the children of handicapped parents, figures demonstrating that many parents (and therefore their children) would be aided would certainly strengthen its chances of a high priority. If a proposal is for provincial support for a crisis intervention centre then data would be needed to establish, for example, that many local young people were suiciding or being detained by police or were inpatients at the Nova Scotia or I.W.K. hospitals for lack of such a centre.

Ultimately, however, determining priorities among legitimate but competing proposals for needed services is a political rather than scientific process. The Local Committee aids this process by providing a forum in which consensus may be achieved, and Secretariat Staff have the responsibility to carry this consensus and its own recommendations back to the Secretariat. But there is no scientific substitute for political process.

Summary of Chapter VII, "Priorities"

I. More

A) Previous studies emphasized that "more" services were needed, ignoring the setting of priorities and the limits to resources. Research shows that the potential demand for mental health services can never be met—approximately 19 percent of young people could probably benefit from such services—so that priorities must be set. Government can only provide the most necessary services.

II. Guidelines

A) Decisions concerning the range of services to be available at a YHC, as well as the types of clinical expertise required, are to be made in the light of scientific research findings. Such scientific data should involve: 1) epidemiology (the yearly incidence and overall prevalence of the problem); 2) the seriousness of various illnesses—what the consequences are of providing no treatment, for example; 3) the effectiveness of treatment and its costs vs. the likely benefits; 4) what problems are most effectively treated by what kinds of professionals; and 5) whether long-term or short-term treatment is likely to be most cost-effective.

B) Decisions concerning the high-risk target populations to be provided with the combined preventive/research efforts discussed in chapter III are to be made in the light of the scientific literature. Here, two approaches are possible, the targeting of one or more specific disorders, and the targeting of a particular high-risk group (e.g., single parents). While the Secretariat Staff must provide expert advice based on the scientific literature, any preventive program must first be strongly supported by the Local Committee if it is to have any chance of success.

C) Decisions concerning the budgetary priority of regional programs and facilities (e.g., day care, residential treatment centres) are to be made by the Local Committee with the aid and advice of the Youth Secretariat Staff. This guideline emphasizes the fact that the setting of priorities among legitimate needs may be guided by research findings but ultimately involves political decision-making. The Local Committee must find its own consensus with regard to priorities, though with the guidance of Secretariat Staff.

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Chapter VIII

SPECIAL PROBLEMS OF THE METRO AREA

Children's mental health experts elsewhere in the province may find some irony in the title of this chapter. Those suffering from the lack of services can find it difficult to sympathize with Metro's problems of coordination and division of labor among mental health facilities. But sympathize they should, for as we shall see many of the difficulties of the Metro area stem directly from the lack of appropriate services and facilities elsewhere in the province.

The Izaak Walton Killam Hospital

The I.W.K.H. is the major children's hospital for the Maritime region, with some referrals from Newfoundland and Labrador. Its upper age limit is sixteen (with some exceptions) and there is no lower limit. Family physicians and pediatricians routinely refer their most difficult cases to the I.W.K.H.

The I.W.K.H.'s Department of Psychiatry provides inpatient and outpatient services, consultation, and 24-hour emergency service. Generally, neither inpatients nor outpatients are accepted except upon referral by physicians (though emergency patients may be). Because the I.W.K.H. is a children's general hospital, it can offer a much greater variety of medical services than can a specialized institution such as the Nova Scotia Hospital. This advantage makes the I.W.K.H. a superior facility for diagnostic purposes, since it may initially be difficult to determine whether a young person is retarded, psychotic, neurologically impaired, or whatever. Moreover, the I.W.K.H. is clearly the best facility for a young patient requiring multiple services, e.g., a patient suffering from psychosis and who also requires neurological treatment.

The I.W.K.H.'s outpatient service, according to material provided by the Department of Psychiatry, in addition to supplying general psychiatric care has special expertise in assessing and/or treating:

1. Preschool children with complex developmental problems where multidisciplinary expertise would be helpful—i.e., speech, hearing, neurology, pediatrics.
2. Children with physical problems—epilepsy, diabetes, orthopedics, respiratory—where close liaison with other specialists and I.W.K. Hospital clinics are necessary.
3. Youngsters with diagnostic problems—questionable autism, psychoses, hyperactivity, tics.
4. Victims of child abuse and their families—since the I.W.K.H. has a SCAN (Suspected Child Abuse and Neglect) Committee.
5. Sexually abused children as these children frequently are brought to the emergency room.
6. Children in treatment with community psychiatrists or mental health clinics, where a second opinion is requested.

The I.W.K.H.'s Department of Psychology consists of four units: clinical neuropsychology, developmental psychology, clinical assessment, and behavior therapy. Its staff consists of neuropsychologists, psychologists, and psychological assistants. It has no inpatient beds of its own but instead provides services to I.W.K.H. inpatients in general. At the time of this writing its behavior therapy unit had ceased to provide outpatient services on a regular basis (except in cases in which a second opinion is required).

Members of the Department of Psychology staff (and printed materials supplied by them) made it clear that their Department was not to be considered primarily a mental health (and certainly not a psychiatric mental health) unit: it was a psychological unit with a scope much greater than they felt was suggested by the term "mental health." For example, their (1) clinical neuropsychology unit collaborates closely with the Department of Neurology in treating patients with known or suspected neuropathology (e.g., head injuries, congenital neuroanatomical malformations, etc.). (2) Their developmental unit assesses infants and young children (ages 0-5 years) whose development is lagging seriously behind the norm. (3) Their clinical assessment unit provides general psychometric evaluation for children ages 6-16, particularly for those suspected of some degree of mental retardation. It also provides stress management training (e.g., improved communication skills, deep-muscle relaxation, etc.) for children suffering from chronic pain with no apparent organic cause, for example, or suffering from high anxiety or from tics. (4) The behavior therapy unit applies learning principles to behavioral problems. Examples of the kinds of problems the unit treats would be non-compliance with physicians' instructions, eating and toilet training disturbances, encopresis and enuresis, and sleep disturbances.

At a number of public meetings, parents were interviewed who spoke highly of the I.W.K.H.'s Department of Psychology for its successes in diagnosing their children as suffering from learning disabilities. They were often harshly critical of school personnel, family physicians, and psychiatrists for having failed to do so.[1] A perception of the Department as specializing in learning disabilities is inaccurate on two grounds. The most obvious is that the Department reports that it has ceased to receive large numbers of "school problem" referrals, in part apparently as a result of the long waiting list for appointments past referrals experienced. But even in the past, the Department of Psychology did not specialize in learning problems per se but in neurological and behavioral problems. The perception of the Department of Psychology as having (or as having had) a specialized role in the diagnosis and remediation of learning disabilities seems to reflect more the relative lack of this capacity elsewhere than it does (or did) a major function of the I.W.K.H.'s Department of Psychology.

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[1] One expert suggested that there is a tendency for parents to perceive psychiatrists, social workers, and some psychologists as in some way telling the parents that the child's school problems are really the parents' fault. Because a learning disability diagnosis may imply a neurological problem which presumably was not caused by the parents' behaviour, parents tend to be much happier with this diagnosis. From the point of view of the child, however, clearly what is important is not the allocation of blame or even the specific diagnosis but the provision of an effective programme of remediation. (See chapter VI for further discussion of this point.)

I.W.K.H. Areas of Tension I: Paucity of Services Elsewhere

Paucity of services elsewhere is a major problem shared by the I.W.K.H.'s departments of Psychiatry and of Psychology. Centralizing specialized medical facilities is a necessity for any province and it is important that these specialized facilities be free to devote themselves to the complex cases which justified their creation in the first place. But when even relatively routine cases must be referred to the I.W.K.H. for lack of facilities elsewhere then hospital staff grow over-burdened. The behavior therapy unit of the Department of Psychology of the I.W.K.H., by becoming a largely inpatient service, has ensured that most of its cases will be both complex and serious. Psychology's other units and the Department of Psychiatry, however, do not appear to be in a similar position and their staff complain of the press of patients. Lack of facilities elsewhere may be overburdening them.

But this lack of facilities creates additional problems. Non-Metro area patients and their families are frequently forced to travel to the I.W.K.H., often at considerable expense and inconvenience, because even basic services are lacking in their home area. Moreover, since mental health professionals argue strongly that young people should be treated as close to home as possible, I.W.K.H. treatment for some of these children and adolescents may be less effective than treatment might be at a regional centre. Often the initial referral is made without adequate background information and the I.W.K.H. staff is in a poor position to collect such information for non-Metro patients. It is in an equally poor position to ensure that a treatment plan they devise is actually followed, once the patient returns home. Despite efforts at consultation by I.W.K.H. staff, local personnel may be unable, due to lack of training or time, to implement the plan provided.

The recommendations pertaining to the Youth Health Centres, discussed in chapter VI, should mitigate these problems by increasing mental health services for young people throughout the Province. A recommendation that hospital staff colaborate closely with local personnel in developing a treatment plan in order that it match available resources is also worth making (though I.W.K.H. staff indicate that they already strive to do so).

Increased use of modern electronic communications devices would also be advisable. In non-emergency cases, I.W.K.H. staff may consult far more effectively with non-Metro personnel if they can see video-tapes of patient and patient-family interaction; ideally, a real-time video-telephone link might considerably reduce the number of patients from outlying areas of the Province who at present must be admitted for assessment. Investment in such equipment is likely to prove cost-effective. Even where funds are at present lacking to purchase this equipment, it is recommended that I.W.K.H. and Youth Secretariat Staff explore this possibility and take the initial step of standardizing equipment formats, so that facilities do not purchase incompatible equipment in the future.

I.W.K.H. Areas of Tension II: Metro vs. Province

The I.W.K.H. serves both the Metro area and the Province as a whole, and here again we have tension. There is a tendency for Metro area residents (or at least referring physicians) to expect the hospital to provide primary, secondary, and tertiary services, while non-Metro residents can expect only tertiary and some secondary services. For example, the I.W.K.H. has at times offered group therapy for adolescents. This needed service has been criticized in some quarters as penalizing non-Metro area residents. Obviously, group therapy and other outpatient services can only be made available by the I.W.K.H. to patients residing in the Metro region, in effect discriminating against those from other parts of the Province. On the other hand, by restricting behavior therapy services to inpatients, the I.W.K.H.'s Department of Psychology is vulnerable to the criticisim that it in effect is withholding needed services from Metro residents.

The solution to this problem is for the I.W.K.H. to stress inpatient services (as one unit of the Department of Psychology has already done) and to aid and encourage purely Metro facilities—the Atlantic Child Guidance Centre in particular—to provide needed outpatient-type services. Exactly how this aid might be arranged is discussed in this chapter under the heading of "division of labor" (p. 17).

I.W.K.H. Areas of Tension III: Teaching vs. Clinical Functions

All medical school-affiliated hospitals share the problem of possible conflicts between responsibilities for teaching and responsibilities for providing patient care. Tensions are likely to arise over the division of staff time and over admissions policies.

The first of these possible problems is the more apparent: how are hospital staff to divide their time between training students, interns and residents on the one hand, and caring for patients on the other? Fortunately, much patient care is training in that the students, interns and residents are directly involved. Nevertheless, supervision and training of students does take time. Reducing the absolute number of patients accepted might provide for more leisurely instruction of students but one can hardly recommend that the region's major tertiary care facility for children and adolescents do so: where else, after all, are seriously ill young people to go?

An obvious course is to increase staff (and, indeed, hospital) size, and there is no doubt that such a recommendation merits consideration. But perhaps not as a matter of the highest priority. Aside from problems of equity—it is hard to justify increasing Metro services when so much of the Province has so little—additional staff tend to create additional demand and soon staff burden is likely to be as great as it was previously (a phenomenon discussed in chapter II).

The solution seems to lie along two lines. The first is to reduce the number of patients served not by turning the seriously ill away but by increasing the competence of facilities elsewhere. The prior recommendations for Youth Health Centres are intended to do this. So too are the prior recommendations for providing for video communication with outlying facilities. Earlier recommendations for reducing outpatient as opposed to inpatient services should be especially effective here. In effect, the pressure on time caused by I.W.K.H. staff having both teaching and clinical functions provides strong reinforcement for many of the previous recommendations.

What, however, of tensions affecting which patients are accepted when? The teaching function requires that patients with a wide range of problems must be accepted. While no doubt all of these patients can and are treated appropriately at the I.W.K.H., at least some could also be served elsewhere. The I.W.K.H.'s Department of Psychiatry accepts outpatients who could also be accepted by the Atlantic Child Guidance Centre, such as those requiring family therapy, for example, or who may be suffering from problems lacking medical complications.

This duplication situation is not necessarily a problem: it becomes one only when we consider: (a) that most of the Province has no local outpatient mental health facility specializing in young people but that the Metro area has three (the I.W.K.H.'s Department of Psychiatry, the Nova Scotia Hospital, and the Atlantic Child Guidance Centre's three branches plus its Spryfield and North End Halifax Community units); (b) that the I.W.K.H. Department of Psychiatry complains of being overburdened by the number of patients it must treat; and (c) that referring agents have no way of knowing whether their referrals will be accepted by the I.W.K.H. Since the solutions to these problems obviously involve coordination and cooperation among Metro facilities, further discussion of them must await p. 17's discussion of "division of labor." Here, only a recommendation directly relevant to the I.W.K.H.'s teaching function should be made: There must be increased training of I.W.K.H. interns and residents at the Atlantic Child Guidance Centre. Aside from the fact that that is where most of the outpatients will (or at least should) be, increased experience on the part of the young psychiatrists and other physicians in a child guidance setting and in collaborating with social workers and psychologists might help to mitigate, in the future, the problems of professional rivalries discussed in chapter II.

The Nova Scotia Hospital

While the I.W.K.H. is a general hospital for children, the N.S.H. is a mental health facility for all age groups, with an emphasis on short and medium-term patients. In 1981, the average stay at the I.W.K.H. for psychiatric diagnosis patients was 14.6 days including emergency admissions and approximately 40 days for non-emergency admissions. For the N.S.H., the average stay for the 0-19 age group was 81.7 days (See table 28 in chapter IV for details.) Another difference between the two hospitals is that the I.W.K.H. accepts children from birth to age sixteen while the N.S.H. deals with children and adolescents from the ages of five to nineteen. Finally, as table 24 in chapter IV shows, where the I.W.K.H.'s patients are distributed among a rather wide range of psychiatric diagnostic categories, a very large proportion of the N.S.H.'s young inpatients suffer from conduct disorders (over 60 percent for the five to fourteen age group inclusive, though that figure falls to 28.3 percent for the entire 5-19 age group, compared to 12.2 percent for the I.W.K.H.'s 0-19 group).

Two units at the Nova Scotia Hospital treat children and adolescents. The McKay Children's Unit serves the ages of approximately five to twelve. The adolescent (Princess Alexandra) unit serves the thirteen to nineteen age group. In addition, outpatient services are provided for discharged inpatients and for individuals assessed who do not require inpatient care but do require treatment. There is one child psychiatrist and one psychiatrist specializing in adolescents at the Nova Scotia Hospital, other staff members consisting of social workers, nurses, psychologists, teachers, developmental workers and occupational therapists.

Inpatients vs. Outpatients

Much of the earlier discussion of treatment of outpatients at the I.W.K.H. pertains to the N.S.H. as well. Though the N.S.H. treats proportionately fewer mental health outpatients (in the 0-19 age range) than the

I.W.K.H., and though its outpatients are not required for teaching purposes, it too can make the argument that continuity of care requires that a facility provide outpatient services to its own discharged inpatients. Like the I.W.K.H., its policy of providing outpatient services to those whom it has assessed regardless of whether they are its discharged former inpatients is open to criticism: that is, such outpatient services favor Metro area residents at the expense of those living elsewhere in the Provinces, while duplicating a service already quite available in Metro. Once again, however, further discussion of this topic must be deferred until p. 17's discusion of "division of labor."

A Caricature

At times, in interviewing, there almost appeared to be two Nova Scotia hospitals, the one described by its staff and the one caricatured by many mental health, social service and educational personnel throughout the Province. In the caricature—and the term is used deliberately to forestall any claim that Once More For Children endorses these harsh criticisms--the N.S.H. is portrayed as refusing to do its job by frequently declining to accept troubled and troublesome young people for whom no other facility is open. In this view, the Nova Scotia Hospital "must" accept such patients and is shirking its responsibility when it refuses to do so. When information on specific instances was requested it was stated that the "refused" young people very often had either already been at the Nova Scotia School for Boys in Shelburne or the School for Girls in Truro, or else were described as having these institutions in their future. These rejected referrals to the N.S.H. tended to be out-of-control youngsters, children and adolescents whose parents or foster parents were unable or unwilling to "handle" them and who were too disruptive for any alternative facilities (e.g., group homes) and for whom previous treatment had failed.

The complaint of ineffective treatment was heard only somewhat less often than that of the rejected referral. That is, those young people who did spend some months as N.S.H. inpatients were reported to have been "just as bad as before" upon return to the home community. An additional complaint was that the treatment plans accompanying former N.S.H. patients or those seen only for assessment were unrealistic and prepared without consultation with local authorities.

For some social service and educational professionals, the N.S.H. is seen as the facility that is supposed to "cure" a troubled youngster in a few months of problems developed over many years and reinforced by his or her recurring social interactions at home and in school. Others, more realistically, saw a stay at the N.S.H. as a way to relieve pressure on the community and family. In the absence of community-based aftercare programs, however, such respites tend to be nothing but respites. There is little gratitude for this temporary relief on the part of the mental health-social service-educational communities. They tend to view the N.S.H. as a place-of-last-resort, comparable to the Nova Scotia School for Boys or the School for Girls. Referral to the N.S.H. is felt to be a kind of admission of failure.

The Staff View

What of the staff of this most stigmatized of all mental health facilities? Theirs is a second Nova Scotia Hospital, a courageous victim, struggling to do its best in spite of inadequate staffing, funding, and appreciation. The I.W.K.H. can always refer to the N.S.H., but to whom can the N.S.H. refer? Despite efforts to screen admissions, as a provincial mental hospital the N.S.H. must admit all those who have been remanded there by a provincial judge or who have been medically certified. The admission takes place regardless of the hospital's opinion as to the appropriateness of the remand or certification, or the suitability of the patient for its existing programs.

N.S.H. staff complained of the lack of alternative facilities. Some pointed out that a large proportion of their patients suffered from "conduct disorder," a condition widely believed to be difficult to treat and to have a poor prognosis, particularly when the sufferers are young males with problems of aggression. They questioned whether such patients belonged in the N.S.H. Reducing the proportion of patients with this diagnosis would, presumably, increase the effectiveness of the hospital's treatment programs for young people. They felt that other, perhaps non-hospital facilities, should be created for the present conduct disorder patients.

Many N.S.H. staff members deplored the lack of community support services for younger patients in most of the Province--"halfway houses" and group homes in particular—and some suggested that, while they could usually succeed in managing the patients' behavior in the hospital, they were less optimistic about permanent improvement once the young person left the institution. "Follow up" and "after care" of former hospital patients is the responsibility of the Health Units (the community health nurses in particular) and the local mental health facilities, but neither the N.S.H. staff nor the members of local communities felt that this follow-up was particularly effective in the case of children and adolescents.

N.S.H. staff respond to the multiple pressures on them and to the fact that their facility clearly serves as the Provincial scapegoat for problems in the mental health care delivery system by striving to screen their intake of patients. Some staff members would prefer to limit their younger patients to those who have cooperating parents or other adults (believed necessary for effective therapy), and to limit the adolescents to those likely to benefit from existing programs and unlikely to disrupt the therapy of others. Some wished to reduce the large proportion of their patients with "conduct disorder" diagnoses. Others, however, pointed out that many patients with the initial diagnosis of "conduct disorder" subsequently revealed themselves to be suffering from other psychiatric conditions in addition to or instead of conduct disorder. Such patients would undoubtedly suffer even more were they to be excluded from psychiatric care, and staff tended to be proud of their success with this group.

It is clear that the N.S.H. is hurt—even victimized—by the absence of alternative facilities and of appropriate community support services throughout the Province and of clear lines of communication to these. It is equally clear that the hospital would benefit greatly if the suggestions for special facilities discussed in chapter IX were to be implemented. The Youth Health

Centres recommended in chapter VI would also be of considerable value to the N.S.H. as a means of providing both after-care and (it is to be hoped) an alternative to referral to the N.S.H. in the first place.

But it is equally clear that the role of the Nova Scotia Hospital in providing mental health services for children and adolescents needs to be redefined. That redefinition must deal both with the functions the N.S.H. can serve for the Province as a whole and the functions it can serve for the Metro region. However, the task of suggesting a redefined role for the N.S.H. must wait until the role of one of its Metro area partners, the Atlantic Child Guidance Centre, has been discussed.

The Atlantic Child Guidance Centre

The Atlantic Child Guidance Centre has branches in Halifax, Dartmouth (opposite the Nova Scotia Hospital), and (since 1981) Sackville. Though in the recent past its staff of 25-30 full and part-time professionals consisted largely of social workers and psychologists, the amount of psychiatric time available to its clients has now expanded[2].

The ACGC sees its missions as three: (1) providing assessment and treatment to troubled young people and their families on an outpatient ("client") basis (with an upper age limit raised, during 1981, to 19); (2) community consultation with other agencies and organizations concerned with young people, as well as public education (including courses related to child management); and (3) providing education and training to practicing and in-training professionals concerned with children and adolescents.

If the Nova Scotia Hospital serves as the provincial scapegoat, the ACGC serves as provincial paragon, the main criticisms directed toward it showing signs of a flattering envy (e.g., "why did Sackville get a branch and not my community?"). Within the Metro area, too, there is relatively little substantive criticism of the ACGC from Metro social service agencies.

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[2] The ACGC prefers the term "client" to "patient", thereby emphasizing that agency's non-medical character. Its staff feel that the term is used because, in their opinion, it is less stigmatizing than "patient" and is less suggestive of illness, while by implication stressing the voluntary nature of the treatment relationship.

Several professionals did complain, however, that the ACGC made too little use of physicians in triage and initial assessment and tended to be relatively indiscriminate in its enthusiasm for family therapy. Neither the statistical data in chapter IV nor the tables in the ACGC's annual reports support the latter allegation, however, while the past paucity of psychiatric time has apparently resulted from difficulty in retaining psychiatrists rather than from disinclination to make use of them. Related to the complaint of too little physician time was the complaint that neither the director nor the branch heads of the ACGC were physicians (though this has not always been the case). Since these positions require full-time personnel and since no psychiatrist at present works full-time with the ACGC, it is understandable that the positions are held by social workers and psychologists. Though these may consult with medical and other professionals, the responsibility for their important decisions does indeed lie with them.

According to the 1981 ACGC annual report, 27 per cent of its referrals (342 of a total of 1246) were received from physicians and hospitals. Since parents are believed more likely to take their children's problems to the family doctor than to any other agency, some individuals suggested that this figure is low. It may be, as some physicians gave evidence of reluctance to refer to what they perceived as a non-medical facility. On the other hand, statistical data on "referral sources" indicate only the immediate agency making the referral. It might be that some physicians "refer" to the ACGC simply by suggesting that the parents make an appointment themselves.

The ultimate "horror story" several physicians produced was that of the patient referred to the ACGC with an organic problem and offered family therapy instead of medical treatment. This possibility—which is real—was presented as an argument for physician participation in at least the initial stages of assessment. The argument is not weakened by the standard counter-argument: physicians are liable to offer medical treatment when family therapy (or counseling, behavior modification, etc.) is required. Presumably, the latter eventuality is unlikely when the "physician" is a psychiatrist or pediatrician working in close collaboration with other ACGC staff.

This Study recommends that the extent of physician participation in triage, assessment and referral decisions at the ACGC be increased. Three factors ground this recommendation: (1) Other recommendations strive to limit the range and number of outpatients the N.S.H. and I.W.K.H. are to treat and transfer this responsibility to the ACGC. The ACGC will therefore be treating a wider range of clients and so require more medical screening of patients than has previously been the case. (2) Other recommendations will increase the ACGC's involvement in the training of psychiatric residents and interns. (3) Some family practitioners and other physicians as well as some educational and social service personnel are reluctant to refer to a non-medical mental health professional. Though such reluctance may only rarely be justified its existence is a social fact. Until such time as education changes that fact, providing the ACGC with more medical participation will serve to reassure those who want a "doctor" to see their referrals.

This Study does not presume to specify the manner in which the ACGC is to increase physician participation in triage, assessment, and referral decisions. Nor does it specify the types of physician who will participate (e.g., pediatrician with expertise in behavioral pediatrics, pediatric neurologist or psychiatrist, community psychiatrist, etc.). Finally, any interpretation of the recommendation for greater medical participation in the ACGC to mean that this facility must in some way be directed or controlled by a physician is false.

A different type of criticism of the ACGC made in a few instances was the complaint that the facility refuses to treat clients who lack cooperating parents—in this case, parents who provide permission for their child's therapy but do not cooperate in actual treatment or who sabotage it by, for example, not bringing the child for appointments. The recommendation made previously in connection with the Youth Health Centres (chapter VI) is here repeated with respect to the ACGC: even though it may be difficult to provide treatment for young people whose parents do not or cannot cooperate, every effort to provide such treatment must be made. But in the case of the ACGC, the recommendation is further strengthened: the ACGC must be the Metro area facility which not only accepts but specializes in treating, on an outpatient basis, young people with inadequately cooperative or absent parents or parent-surrogates. There are, of course, degrees of uncooperativeness and the ACGC staff must develop appropriate procedures and expertise to manage the range of cooperation-related problems. Such procedures might, for example, range from special reassurance of fearful parents to, in extreme cases, requesting assistance from child welfare personnel on the grounds that withholding permission for treatment may constitute neglect as defined by the Children's Services Act.

It was suggested that the ACGC might reduce some of the pressure on the I.W.K.H.'s Department of Psychology by providing more behavior therapy and more developmental assessment. Since this suggestion is in line with the general recommendation that the ACGC should be the primary source of outpatient care for young people in the Metro area, it is specifically recommended that the ACGC explore with the Department of Psychology staff the possibility of the former accepting as large as possible a proportion of the outpatients now treated by the latter. This recommendation may require some extension of the ACGC's current treatment emphases.

At the time of the writing of the Study, the ACGC had put forth a proposal for a court clinic, to be organized and operated under its auspices. This clinic would provide mental health consultation and services to the Family Court and to the young people who come to the attention of the court. This Study endorses that proposal, adding to it one provision: Once the court clinic is organized and operating in a satisfactory manner, it is recommended that it undertake an additional role, that of training. At least one staff member from each YHC in the Province should eventually be rotated through the court clinic, thus enabling all YHCs to develop some expertise with the mental health needs of the courts and of young people brought before them.

Other Metro Mental Health Services

All provincial hospitals occasionally receive psychiatric emergency cases in which the patients may be adolescents. The I.W.K.H.'s emergency department receives psychiatric emergencies involving the 0-16 age group (discussed below). The Victoria General Hospital receives a limited number of adolescent psychiatric inpatients, often on an emergency basis. These are usually referred to the N.S.H. or the I.W.K.H. or to private physicians. The Abbie Lane Memorial Hospital formerly treated a number of adolescents and, as part of the Camp Hill Complex, hopes in the future to have a small number of "acute observation" beds available for short-term hospitalization for the 16-20 age group. Finally, most psychiatrists in private practice in Nova Scotia reside in the Metro area and some children and adolescents are presumably being treated by them on a private basis. Private clinical psychologists do the same though no statistics are available as to the number of young people they treat.

Social Service Agencies

There are probably more social service-type agencies in the Metro region than in the rest of the Province taken together. In Dartmouth, child welfare services are provided directly by a regional office of the Department of Social Services, while in Halifax these services are provided by the Halifax Children's Aid Society. The Department of Social Services also funds in whole or part a number of facilities in Metro and elsewhere related to mental health care for the 0-19 age group, including the provision of most non-medical services for the mentally retarded. Within Metro itself, the Residential Treatment Centre on South Street provides psychodynamically oriented "milieu therapy" for a small number of adolescents. But no detailed analyses of Department of Social Services facilities as such (or special services offered by education districts) were made as part of the present Study (though general attention was paid to them). A listing of Metro-area helping agencies is available from the "Help-line" (a crisis intervention and directory-type service), while the Department of Social Services itself has a listing of all services which it helps subsidize.

Division of Labor and Coordination of Services

Table 40 is an up-dated revision of one originally prepared in 1980 under the auspices of the Metropolitan Mental Health Planning Board. It gives a very approximate image of the current division of labor among the mental health facilities for children and adolescents for the Metro area. The following summary recommendations would alter and simplify the division of labor it presents:

The I.W.K.H. would deal with inpatients referred from anywhere in the Province, pre-school children, children and adolescents with special diagnostic or medical problems requiring the services of more than one hospital department, and all young patients needing only short-term hospitalization. Its outpatients would consist primarily of its own former inpatients. Its students/residents' need for contact with a wide variety of outpatients, and the expressed desire of some of its staff for contact with such a wide range, would be met by assigning students and staff on a part-time or rotational basis to the ACGC, thereby increasing the amount of psychiatric time available to that facility and giving members of the various mental health professions experience in working together. (Alternatively, the I.W.K.H. would admit as many "routine" outpatients as its staff felt were needed for training purposes. This is a much less desirable option, since it perpetuates duplication of outpatient facilities in Metro while missing the opportunity to mitigate professional rivalries through the experience of psychiatrists participating actively in a child guidance centre.) The I.W.K.H. would continue to consult with mental health and other professionals throughout the Province.

The N.S.H. would continue to be responsible for short and medium-term care for age 5 - 19 inpatients. However, many of the referrals it now finds

TABLE 40: ADMITTING POLICIES FOR MENTAL HEALTH PROGRAMS FOR
AREA AND FINANCED BY THE DEPARTMENT OF HEALTH OF

Purpose of this Chart: To facilitate the co-ordination
provide background information
who are difficult to service.

AGENCIES IN METRO	AGE LIMIT	AREA SERVED	PRESENTATION PROBLEMS	RANGE OF SERVICES	CASELOAD CAPACITY
A.C.G.C.	0-19	Halifax City Dartmouth City Halifax County	Emotional, behavioural, Family & psychiatric problems	Assessment & Rx Family & Gp Therapy Consult to other agencies, Public Educ., Comm. Consult., Teaching Services	Referrals-1500 Caseload -1250 Consults -1300 (all per year)
I.W.K.	0-16	Maritime Provinces	Total range of problems with special skills for Children with physical & emotional problems & others	Emerg/Crisis Intervention, Diag. Serv. (Inpt & O/pt.) short term therapy (psycho., family behavioural & pharmaco-therapy)	Inpt. 10 beds in Psychiatry Unit. 1-2 beds on Care-By-Patient Unit especially for young children for brief diagnostic or behavioural management stays O/pt. Active case load-250 New Patients-400
Camp Hill Hsp.[2]	16-19	Halifax City & County	Schizophrenia, Depressive illness, Neuroses, Personality disorders	General Psychiatry Assessment, Consult., Crisis intervention. Wide range of treatment. O/pt., Inpt., Day Care, Community Clinic. Psychology (Behav. Mod.)	Inpt. 3, O/pt. 75 (approx) Day Care 2 Comm. Clinic 5 Chronic
N.S.H. Children	1-12	Province of Nova Scotia	Any psychiatric disorder for which inpatient treatment seems appropriate	Inpt. day pt., night pt., limited O/pt. follow-up cases	30 inpts. 6 places for partial hospitalization
N.S.H. Adoles.	13-19	Province of Nova Scotia	All types of mental disorder (except alcohol) problems of adjustment, school difficulties	Inpt. & Assessment clinics, O/pt. day care, some special education	30 inpts. 7 day care places spaces for O/pt
V.G.H. (9A)	16+	Province of Nova Scotia	Depressions, Anorexia Nervosa, Schizophrenia, (incipient, latent or overt), personality disintegration or decompensation with current stresses	Short-term therapy (e.g., chemotherapy, physical therapy, psychotherapy, family counselling, behaviour and group therapy, ward milieu, etc.), consultation, liaison, emergency services, diagnostic service	4-5 adoles.

1. Based on a July, 1980 table prepared by the Children's Study.
2. Camp Hill Hospital now contains the former Abbie Lane present (February, 1983) arrangements are temporary.

CHILDREN/ADOLESCENTS LOCATED IN THE HALIFAX-DARTMOUTH METRO

NOVA SCOTIA.[1]

of services, close gaps, and reduce overlapping and to
for interagency discussions relating to those children

AVERAGE LENGTH OF TREATMENT	WAITING TIME	STAFF NUMBERS & TYPES (ALL SERVICES COMBINED)	TEACHING PROGRAMMES	UNMET NEEDS	OTHER CRITERIA
5 sessions over 8 month period.	Regular - 2-3 weeks	1 Ex. Dir. 1 Bus. Mgr. 6 Secretarial 3 Psychiatrists 18 Therapists (Psychol., nurses, S.W., Nursery)	Prog. for students of S.W., Medicine-Family Medicine & Psycho. Resident, Nursing - Under & Post Graduate	Learning disabilities, court work, Summer camps	Will not assess unless referral is for Rx. also Consult. provided for other CMHC's
Inpt.- 2 months O/pt.- 2 months	Inpt.- 1-6 months according to urgency. O/pt.- 1-2 months	Inpt.-Psychiatrist -Resident -8 R.N.s -7 Child M.H. Workers -1 M.S.W. -0.4 Teacher -Occ. O.T., Speech, - Physio. Consultation -0.2 Psychology O/pt.-3 Psychiatrists - 2 Residents - 1. M.S.W. - 1 P.H.N. - 0.1 Psychological Service	Med Students 1-4 years. Psychiatric & Pediatric Residents, Nursing Students	Adoles. serv. need separate clinics, wards, gp. programs, psycho. diag. services for retardates & learning disabilities	Need referral by physician except in emergency. Inpt.:Require involvement of parents or guardians. O/pt. Require involvement of parents and guardians
Flexible but no Long-Stay (i.e. 3 months +)	Urgent Assessment (O/pt) - same day Non-urgent - 1-2 weeks (O/pt. and Day Care) Inpt. Admission - as beds available (no certified cases at present)	4 Full-time, 7 part-time, psychiatrists 7 Psychologists 8 Psychiatric Social Workers 7.5 Occupational Therapists 17 RNs 5 Psychiatric residents 1 Intern M.D.	Dalhousie Dept. of Psychiatry Head Office Teaching to Med U/Gs (years 2-4). Psychiatric residents (all years) Rotating interns Nurses (in-service) All Staff (Grand Rounds)	Inability to admit severely psychotic patients (incl. adolescents)	Adolescents (16-19) can be admitted if suffering from discrete psychiatric illness but not if suffering from acting out personality disorder
Inpt. 6-9 months	Variable usually 1-6 weeks	½ S.W. 1 Psycho. 1 O.T. 4 R.N.'s 26 Devel. Workers 6/10 Child Psychiatrist	Comm. Service Worker; 2 for 3 wks. p.a.; 2 for 9 wks. p.a.; Child Devl. Workers; 1 for 6 wks. p.a.; 2nd & 4th yr. med. students Next yr. psychiatric resident	Spec. Foster Homes, Gp. Homes, Comm. facilities for O/pt. services	Educable, parents/guard. must participate in re-training program; wards must have foster parents. O/pt. Rx. already tried
Inpt. 3 months	Variable usually	1 Psychiatrist 1½ S.W. 1 O.T.	4th yr. Med. students. Next year psychiatric resident	Spec. Foster Gp. Homes, Voc. Training Programs, Job Experience	Exclusions: over 19 unless spec. referral, mentally retarded; married' charged with serious criminal offence, primary alcohol and/or hard core drug addiction
3-6 weeks	1-3 weeks	5-6 psychiatrists (FT & PT) 22 Nurs. Staff 1 O.T. 1 S.W.	Medical Students (all years) Residents (psychiatry and other special), Interns, Nursing Students, O.T. Interns, Student Ministers	Unit is not geared particularly to adolescent needs (present caseload too small for effective programs; e.g., groups, etc.)	

Adolescents' Committee of the MMHPB and up-dated for this

Hospital. The latter is currently being refurbished, so
The emphasis is on adult rather than adolescent psychiatry.

inappropriate would instead be referred to alternative facilities, the "hard-to-manage-adolescent" facility recommended in chapter IX in particular. At the same time, additional group homes and halfway houses would reduce average length of stay at the N.S.H., making possible treatment of a larger number of individuals. As with the I.W.K.H., N.S.H. outpatients would consist primarily of its own former inpatients. Staff preferring to deal with a wider range of outpatients would be advised to seek a part-time arrangement with the Atlantic Child Guidance Centre, the Metro area's major mental health outpatient facility for young people and their families.

The ACGC would be primarily responsible for outpatient mental health services for the Metro area. It would develop special expertise in young people with non-cooperative parents (as discussed previously). It would continue its current educational and consultant functions. The role of physicians in triage, assessment and treatment in the ACGC's day-to-day operations would expand. It would increase its range of services to the extent possible in order to reduce the outpatient load of the I.W.K.H.'s Department of Psychology.

Finally, the ACGC, I.W.K.H. and N.S.H would cooperate with Youth Secretariat Staff in aiding the creation and functioning of Youth Health Centres in such a manner that both Metro and non-Metro mental health services for children and adolescents form a single, province-wide network.

Summary of the Rationale

In most of the Province, a troubled young person has at best one outpatient mental health facility to turn to, often with only a limited range of treatment services available. In Metro, a troubled young person (and his or her parents) can choose among the three branches of the ACGC, the I.W.K.H., and the N.S.H. The latter two institutions serve not just Metro, however, but the entire Province. To the extent that their limited and often overburdened staff treat local residents on an outpatient basis, to that extent they are diverting to the Metro area resources needed by the entire Province. Limiting the extent to which the N.S.H. and I.W.K.H. deal with outpatients is a lamentable necessity: lamentable because it restricts the choice now enjoyed by Metro area residents (who also have greater access to private practice mental health professionals); lamentable because the psychiatric staff of these two institutions much prefer to treat a wide range of patients and may find the requirement of affiliating on a part-time basis with the ACGC if they wish to continue doing so irksome. But the limitation is, in the name of equity for the rest of the Province, necessary. And if cooperation among facilities is a goal then this sharing of staff is a relatively painless means of inducing it and of developing a sense of "common fate" among the mental health community's members. The alternative is a total administrative reorganization which would integrate the children's and adolescents' mental health services of the ACGC, I.W.K.H. and N.S.H. under a single directorate. At present, such a drastic course would appear to be both unnecessary and unreasonably disruptive. (It is possible that the "four years later" review of these recommendations proposed in chapter VI will result in a different conclusion.)

A potential drawback to these recommendations is that they might result in the ACGC having "psychiatric time" but no fully involved psychiatrists. This would occur if that "time" resulted from the I.W.K.H. and N.S.H. child/adolescent psychiatrists each spending a small proportion of their time at the ACGC, since no psychiatrists would then be in a position to participate fully in the planning and operation of that facility: each would be just a few-hours-a-week visitor. It is therefore recommended that the ACGC seek to develop a small core of psychiatrists each of whom would devote perhaps 40-50% of his/her time to that facility. Other psychiatrists would then be free to devote only a few percent of their time to the ACGC, if they so chose.

Finally, it must be remembered that the goal of all of these recommendations is the provision of better service for children and adolescents. No recommendation is a goal in itself: each should be evaluated in terms of whether it is working to enhance the actual delivery of services to troubled young people.

The Role of the Children's/Adolescents' Committee of the MMHPB

Once each month, the Children's/Adolescents' Committee of the Metropolitan Mental Health Planning Board holds its luncheon meeting. The Committee consists of representatives from the I.W.K.H., the ACGC, the N.S.H., and appropriate educational and social services facilities. The Committee's task is to plan and coordinate mental health and related services for children and adolescents in the Metro area but participation in it is essentially a voluntary activity of very busy people who have repeatedly requested a full-time coordinator to serve not just as staff for the Committee but to organize such routine matters as which facility should accept which referral today.

This Study recommends not that the Children's/Adolescents' Committee be given its own independent staff member but that a senior Youth Secretariat Staff member be made a member of that Committee, serving the same role here as other Secretariat staff members will serve for the Local Committees recommended earlier (chapter V). That individual is to encourage planning and real coordination of services and report unresolved problems—such as a need for a special facility—directly to the Secretariat itself (that is, a cabinet-level committee). He or she is to strive to reduce competition and duplication of services among facilities.

The Study further recommends that the Children's/Adolescents' Committee be broadened to include two representatives from the I.W.K.H., one a psychiatrist from its Department of Psychiatry (as at present) and the other a psychologist from its Department of Psychology (preferably its director). Though that Department of Psychology prefers to view itself as not just a mental health unit it is at least also that, and it has expertise and a particular orientation which may serve to broaden the scope of the Childen's/Adolescents' Committee.

Agenda

This report suggests to the Children's/Adolescents' Committee that it deal with the following problems but it in no way limits that Committee to these specific matters:

1) Coordination of services between the ACGC and I.W.K.H.'s Department of Psychology. Expansion of range of ACGC services.

2) The creation of a common core assessment program. At present, each facility does its own quite independent assessment of each new referral, including referrals from sister facilities. While it is understandable that any facility would wish to gather some new information of its own, it appears that frequently the assessment process begins as if previous assessments had not taken place. Collecting a common core of agreed upon information, or the use of a standardized diagnostic system, might mitigate what appears to be duplication of effort.

3) A Metro-wide "bed availability" coordinating system, so that in case of emergency knowledge of which facility has a bed available is readily obtainable.

4) The development of a system whereby a referral for assessment deemed "inappropriate" by all facilities is accepted by the least inappropriate facility.

5) The development of Metro-area psychiatric emergency services for children and adolescents. At present, the I.W.K.H. has a 24-hour emergency service but there have been complaints that some disruptive patients have disturbed non-psychiatric emergency patients. One solution might be a separate, sound-proofed psychiatric emergency unit at the I.W.K.H. The Children's/Adolescents' Committee should devise with the aid of its Youth Secretariat staff member both a short-term and a long-term plan for creating a 24-hour psychiatric emergency facility. The facility should be staffed since its patients may behave unpredictably. It should have the capability of "cooling off" a distraught young person so as to permit assessment.

6) Long-term responsibility. In the case of the Youth Health Centre model, it was the YHC itself which was assigned the responsibility of long-term monitoring of troubled young people, and of coordinating the work of the various services and agencies which were in contact with them and their families. For Metro, given the relative density of social service and mental health agencies, any single unit assigned the task of coordinating and long-

term monitoring would be overwhelmed. Rather, the coordinating task in Metro must be assigned on a case-by-case basis, with social service as well as health agencies bearing a portion of the responsibility. The Children's/Adolescents' Committee is charged with developing a system of: (a) determining whether a particular patient requires a coordinating and/or long-term follow-up effort (e.g., children in multi-problem families no doubt require both, while discharged psychiatric inpatients and individuals in the high-risk groups discussed in chapter II would primarily require a long-term follow-up; and (b) devising a system of assigning responsibility for such coordination and follow-up among agencies and services in an efficient and equitable manner. No doubt a centralized, computerized registry of cases will be necessary, as quite possibly will be changes in the Hospital's Act with regard to confidentiality of patient information in order to permit sharing of some data by health, social service, and possibly educational agencies.[3]

7) Regular review of reward system. As was discussed in chapter II and elsewhere in this Study, mental health and other staff are rarely rewarded for cooperating with other agencies and facilities. The Youth Secretariat Staff member serving on the Children's/Adolescents' Committee must take the initiative in regularly (perhaps twice each year) reviewing the incentatives (or lack of them) for cooperation at the level of the individual staff member of the various Metro facilities. For example, what are the criteria for promotion or salary increase, do they include cooperation with other agencies? Should the Secretariat Staff member find that the institutions represented by the members of the Children's/Adolescents' Committee are failing to reward staff for inter-

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[3] A brief submitted by a family court judge illustrates the problem of coordination. In one case described, a woman of 25 with a history of alcoholism was alleged to have abused her young child. In the judge's opinion, this mother was ignorant of how to go about being a parent, in spite of regular visits from: a "child protection worker, a social assistance worker, a home-maker, a parole officer, a probation officer, the police, a volunteer from a child abuse counselling service, a public health nurse, a housing officer and someone from the hospital". The woman complained that she was confused by all of these visitors giving her advice, since "they all had a different way to handle a problem."

agency cooperation then the Secretariat Staff should take this fact into account in making budgetary recommendations to the Secretariat. (In this manner, facilities as a whole will also have rewards--and penalties--for inter-agency cooperation and its lack.) This task is especially important because this Study has not recommended amalgamation of children's/adolescents' mental health and related services under a single directorate. Such a recommendation, despite its disruptiveness, would make it likely that inter-agency cooperation is rewarded. Should the Children's/Adolescents' Committee and Secretariat Staff fail to ensure inter-agency cooperation by making it part of each facility's internal system of staff incentives, that failure would be good reason for a future review to recommend a full amalgamation of Metro services.

8) Problems of the handicapped. Young handicapped people have special mental health needs which require special expertise. This is especially true of the hearing handicapped, who suffer from present paucity of therapists who are able to sign. It is recommended that one or more Metro facilities be charged with developing special expertise in the problems of the handicapped, and that this special expertise be made available, when needed, both to the young handicapped in Metro and, on a consultation basis, to the YHCs elsewhere.

Summary of Chapter VIII, "Special Problems of the Metro Area"

1. The major problem that the Izaak Walton Killam Children's Hospital (I.W.K.H.) suffers from is paucity of facilities elsewhere, so that it often must provide even relatively routine care, overburdening its staff and requiring children to be transported away from their home communities. Chapter VI's and IX's recommendations for increased mental health services for young people throughout the Province should in time alleviate this problem.

2. Hospital staff must collaborate closely with local personnel in developing treatment plans for non-metro patients in order that they match available resources.

3. Modern communications facilities, including a real-time video link, would permit I.W.K.H. staff to observe childen elsewhere, thereby reducing the number of children who must be physically transported to that facility. Even though funds for this capability may not be available immediately, I.W.K.H. and Youth Secretariat Staff should take the initial step of standardizing equipment formats now so that facilities do not purchase incompatible equipment in the future.

4. The I.W.K.H. now provides substantial mental health outpatient services that necessarily are primarily available to Metro-area residents. Since the I.W.K.H. is responsible for the entire Maritime region (and, to some extent, Newfoundland), it can be argued that to the extent the hospital emphasizes outpatient at the expense of consultative and inpatient services it is in effect discriminating against non-Metro residents. The I.W.K.H. should therefore stress inpatient mental health services while aiding and encouraging purely Metro facilities—the Atlantic Child Guidance Centre in particular--to provide needed outpatient services. At the same time, it should continue and expand its consultative and traveling clinic services for non-Metro areas.

5. At present, the I.W.K.H.'s treatment of substantial numbers of psychiatric outpatients duplicates, to a considerable extent, services also provided by the three branches of the Atlantic Child Guidance Centre (ACGC). This duplication becomes a problem when we consider that: (a) most of the Province has no local outpatient mental health facility specializing in young people at all but the Metro area has three (the I.W.K.H.'s Department of Psychiatry, the Nova Scotia Hospital, and the ACGC's three branches); (b) the I.W.K.H. Department of Psychiatry complains of being overburdened by the large number of patients it must treat; and (c) referring agents have no way of knowing whether their referral will be accepted by the I.W.K.H., or which one of the various outpatient facilities in Metro would be most appropriate for a given young person.

6. However, the I.W.K.H. now requires, as a teaching facility, a sufficient range of psychiatric outpatients.

7. On the one hand, the ACGC has had problems in the past in acquiring sufficient psychiatric staff time. On the other hand, one partial solution to the problems of professional rivalry discussed in chapter II is to train physicians—especially child psychiatrists—in a multidisciplinary context. Giving some medical student and resident training responsibility to the ACGC would provide this multidisciplinary context for the students, aid the ACGC by increasing the amount of psychiatrist time now available to that facility, and help the I.W.K.H. by relieving it of the teaching-required wide range of outpatients it must now service. It is therefore recommended that the ACGC formally arrange with Dalhousie University to accept substantial medical training responsibilities, with appropriate adjustments to its staff (that is, some I.W.K.H. staff will be required on a part-time basis to help train the medical students and residents who will now be at the ACGC).

8. Many mental health and related professionals see the Nova Scotia Hospital (N.S.H.) in a very negative manner. In part this is because many in the helping professions see the institution as the placement of last resort which must take young people who are not accepted by other facilities. N.S.H. staff reject this role and attempt to screen patients, accepting only those likely to benefit from the hospital's programs. This discrepancy in perceived role causes much friction between N.S.H. and other helping profession staff throughout the Province. Its ultimate cause is the severe lack of alternative facilities, leading to the N.S.H. being cast in the role of last resort.

9. Another N.S.H. problem stems from unrealistic expectations on the part of some members of the children's/adolescents' services community, who at times appear to expect the N.S.H. to "cure" such problems as conduct disorder. Here, the N.S.H. is in effect being blamed for the state of the art of child psychiatry.

10. N.S.H. staff complain, with justification, that their efforts are often undercut by lack of community support and aftercare programs, once the young person is separated from the hospital. The recommendations in chapters V, VI and IX should help to alleviate this problem.

11. The Atlantic Child Guidance Centre (ACGC) is, in comparison with the N.S.H., usually praised by the children's services community. What criticisms it receives tend to centre on past shortages of psychiatric staff time and of a non-medical approach to treatment.

12. This study recommends that the extent of physician participation in triage, assessment and referral decisions at the ACGC be increased. Since previous recommendations regarding the relationship between the I.W.K.H. and the ACGC mean that the latter will in the future receive a wider range of patients/clients, the increase in physician participation is a necessity regardless of the validity or lack of validity of occasional complaints about past practices.

13. Pediatrician participation at the ACGC is desirable.

14. Any interpretation of these recommendations for greater medical participation in the ACGC to mean that this facility must be in some way directed or controlled by a physician is false.

15. Like the YHCs elsewhere, for Metro the ACGC must be the facility which not only accepts but specializes in treating, on an outpatient basis, young people with inadequately cooperative or absent parents or parent-surrogates.

16. The ACGC should explore with the Department of Psychology of the I.W.K.H. (which is no longer providing behavior therapy on an outpatient basis) the possibility of the former accepting as large as possible a proportion of the outpatients now (or until recently) treated by the latter. This recommendation may require some extension of the ACGC's current treatment emphases.

17. The ACGC should seek to develop a small core of psychiatrists each of whom would devote perhaps 40-50 percent of his/her time to that facility. Other psychiatrists would be free to devote only a few percent of their time to the ACGC, if they so chose, but the "core" would be sufficiently involved in the ACGC to participate in the planning and operation of that facility.

18. The AGCG, I.W.K.H. and N.S.H. are to cooperate with Secretariat Staff in aiding the creation and function of YHCs in such a manner that both Metro and non-Metro-mental health services for children and adolescents form a single, province-wide network.

19. The Children's/Adolescents' Committee of the Metropolitan Mental Health Planning Board at present serves as coordinator of Metro-area mental health facilities. It is here recommended that a senior Youth Secretariat Staff member be made a member of that Committee, playing the same role here as other Secretariat Staff members will play for the YHCs.

20. It is recommended that the Children's/Adolescents' Committee be further broadened to include two representatives from the I.W.K.H., one a psychiatrist from its Department of Psychiatry (as at present) and the other a psychologist from its Department of Psychology (preferably its director).

21. The expanded Children's/Adolescents' Committee should put the following matters on its agenda:

    a) Coordination of services between the ACGC and the I.W.K.H.'s Department of Psychology. Expansion of range of ACGC services.
    b) The creation of a common core assessment program.
    c) A Metro-wide "bed availability" system.
    d) The development of Metro-area psychiatric emergency services for children and adolescents.

e) A means of assigning long-term responsibility for troubled young people (assigned in non-Metro areas to the YHC).

f) Regular review of all facilities' internal reward systems, so that staff members be provided with incentives for inter-agency cooperation.

g) Assigning responsibility for developing special expertise in the problem of the handicapped young, with special attention to the hearing handicapped.

Chapter IX

SPECIAL FACILITIES

This brief chapter recommends procedures for the planning of special mental health and related facilities for children and adolescents. It does not provide detailed recommendations for all needed facilities—that task proved to be beyond the capability of the Study—but it does establish procedures and set some priorities.

During the Study's course, many excellent and thoughtful requests for specialized facilities were received. Creating all of them would no doubt be financially impossible. And yet, some are so needed that, for lack of them, lives may be blighted. Some facilities must serve the Province as a whole but most should be primarily regional in nature. In all cases, final recommendations should be made by the Staff of the Youth Secretariat.

Province-Wide Facilities

Ideally, we would have no province-wide facilities at all, only regional ones. As the head of one social service agency put it, "You can't send the child to be treated away from his home environment. It's not like sending a watch to be fixed." But where numbers are small and expertise expensive and scarce, facilities must serve the Province as a whole.

Nova Scotia requires a residential treatment centre for "unwanted" or "impossible" or "hard-to-manage" or "hard-to-place" children and adolescents. Most though not all such young people are wards of social service agencies or the Department of Social Services. These are often the young people who have been through many foster homes and are unwanted by them. They may have been previously treated by mental health facilities which now refuse to accept them, perhaps on the grounds that the young people are too disruptive and prevent the treatment of other patients or have problems which are "social" rather than "psychiatric" in nature. Existing group homes and other residential facilities are similarly closed to them.

What happens to these young people today? Several social service personnel suggested that they are often sent to severely inadequate foster homes—or taken temporarily to the homes of the social service workers themselves—because there is nowhere else to send them. Many of these young people eventually (or repeatedly) come before Family Court judges some of whom complained, in some instances, of being forced to send a child or adolescent to the School for Boys or the School for Girls only because there was no alternative available. A senior staff member of one of those two facilities described his institution as having two populations, one of young professional criminals and the other of young people badly in need of treatment. (Though some case work and psychiatric treatment is provided at both institutions, they are primarily correctional facilities rather than oriented towards treatment.) Some social service personnel argued that the Nova Scotia Hospital is the proper place for disturbed and disturbing young people but the staff of that facility is not happy with a "placement of last resort" role (see chapter VIII, "Special Problems of the Metro Area," for further discussion). Experienced social service personnel report having recognized the names of former "impossible children" in news accounts of violent criminals.

We need at least one residential treatment centre for these especially difficult youngsters. Though their precise number is not known they would probably total between thirty and sixty. A more definite figure could be obtained simply by surveying all child welfare agencies as to the number of young people who have required three or more placements in the preceding six months. However, the imminent proclamation of the new Young Offenders Act may increase the number of children and adolescents requiring the residential treatment facility here recommended.

"Residential treatment" has been defined as "therapeutically directed institutional or group care for emotionally disturbed children in which all possible ways of helping--casework, education, recreation, planned group life, and psychotherapy are utilized and integrated into a clinically oriented and directed treatment plan for the individual child" (Johnson 1982). A residential treatment facility need not be a hospital ward. (Indeed, hospital accreditation requirements mean that a non-hospital facility is likely to be a less expensive alternative.) But the treatment centre must include a full complement of psychologists, psychiatrists, social workers and other staff with substantial expertise in the treatment of children and adolescents. Since it would be serving especially "difficult" young people it must be "secure" or "closed" or have a sufficiently large staff to prevent residents from leaving without permission. It would have to accept a wide age range—perhaps from age nine to age nineteen—and be long-term in nature. Family court judges must be able to remand young people there, but it should also be available to diversion programs. The facility might be constructed under the auspices of the Department of Social Services or of the Department of Health, but the cooperation of both will be needed in running it. It should not be under the Staff of the Youth Secretariat, since that body is to have no programs of its own. Secretariat Staff should, however, play a major role in its planning. The Department of Social Services has in the past considered creating a residential treatment facility perhaps comparable to the one here recommended, and it is here suggested that the Youth Secreterariat urge that Department to resume this planning.

Recently, doubt has been cast as to the effectiveness of residential treatment centres (Barker 1982). It may well be that some of the local committee options discussed below, such as making trained foster parent/therapists available, will in the long run prove more effective (or at least, more cost-effective). It is clear that the research and evaluation programs recommended in chapter VII must be implemented in order that future planners have solid facts upon which to base their decisions. But it is also clear that, right now, we need a residential treatment centre for young people who today have no proper place to go.

Regional Special Facilities and Programs

The Local Committees, in consultation with Youth Secretariat Staff, must order their own priorities: They know their own most pressing needs. But Staff has a special responsibility in considering Local Committee requests, that of taking into account both regional balance of facilities and services and of considering the province-wide network of services. For example, Staff must be certain that locally requested therapeutic group homes and half-way houses are able to function not just in isolation but in helping hospitals to prepare locally implementable treatment plans for discharged patients, while helping themselves to reintegrate into the home community. The most difficult task for both Staff and Local Committee members will be the actual ordering of priorities.

The discussion below briefly indicates a few of the options open to Local Committees. The list provided here is by no means exhaustive and is included only by way of suggestion. Frequently, various options can be combined—for example, a Youth Health Centre might operate a day program (equivalent to partial hospitalization) combined with a residential treatment centre.

Suggested Local Committee Special Options

1) A regional residential treatment facility. Presumably, this facility would accept local residents in need of less intensive care and supervision than the province-wide "impossible child" facility previously discussed.

2) Therapeutic group home. A number of troubled young people would live together under the general care and supervision of an individual or couple with special expertise. Such a facility may be an alternative to hospitalization or to foster care, and might also serve as a "half-way house" for discharged mental patients. (There are only a small number of group homes at present in Nova Scotia and this study did not attempt to evaluate their effectiveness. Comments about them chiefly focused on their small number and their necessary selectiveness.)

3) Specialized foster care. Foster parents can at times function as parent therapists, thereby eliminating the need for hospitalization. This practice is discussed (among many other places) in the Province of Ontario's 1979 Foster Care: A Discussion Paper (Children's Services Division, Ministry of Community and Social Services, pp. 23-24.) For Nova Scotia, such programs would require close collaboration between the local social service agency and the local Youth Health Centre. The latter would probably need to provide some background training for the foster parents and also to make sure that a continuing and supportive relationship was maintained between the parents and the child's principal (YHC) therapist. It would be necessary for parent-therapist foster parents to receive a multiple of the current foster parent rate (in accordance with recommendation number 15 of the 1978 Final Report of the Task Force on Foster Homes, prepared on behalf of the Nova Scotia Family and Child Welfare Association). Secretariat Staff should consider requesting the Department of Health to contribute to these special rates when the alternative would be the child's hospitalization (which is likely to be far more costly than even generous payments to foster parents).

4) Day treatment centres. A day hospital program or "partial hospitalization" refers to a program in which patients are treated during the day much as if they were inpatients but spend their nights and possibly take some of their meals elsewhere. A day treatment centre would provide much the same service but independently of a hospital. This independence would reduce expense, since hospitals are 24-hour facilities and day treatment centres are not. Hospitals also have, as was noted previously, special accreditation requirements which tend to raise costs. A Youth Health Centre might collaborate with a social service agency, a district school board or (for very young children) a day care centre in making a day treatment facility available.

5) Crisis intervention centres. Where does one go, whom does one call, in case of desperation, despair, disorientation caused by street drugs, etc.? Many communities wish to have crisis intervention centres, usually staffed on a 24-hour basis, so that there will always be at least a telephone number to call. This service is usually considered especially important for adolescents.

6) Respite care. Parents of both mentally and physically handicapped children frequently (and often emotionally) raised the need for respite services for themselves. Such services are also needed for parents of "high risk" children. They may be considered "preventive" mental health measures both for the parents and for the children, since the stress of continuous caring for handicapped youngsters, with the attendant sense of isolation from others, is immense. Respite care is conceptually similar to the "homemaker" services many social service agencies already provide. While the homemaker looks after cooking and cleaning, or teaching these skills, the respite worker takes over the care of the handicapped young person for perhaps one day or evening each week, permitting the parent or guardian a brief but regular respite. The service might be extended to include a teaching function in which the worker helps the parent or guardian to learn how to cope with some of the problems which arise.

Summary of Chapter IX, "Special Facilities"

1. Nova Scotia requires at least one province-wide residential treatment centre for the "impossible" or "hard-to-manage" child with a capacity of from 30-60 young people. It need not be a hospital ward. It will require the cooperation of both the Department of Health and the Department of Social Services to operate. The Department of Social Services has in the past considered creating a residential treatment facility perhaps comparable to the one here recommended, and it is suggested that the Youth Secretariat urge that Department to resume this planning.

2. The Local Committees, with the aid and advice of Youth Secretariat Staff, must order their priorities for regional special facilities for young people. The list below is not intended to be exhaustive:

   a) A regional residential treatment facility.
   b) A therapeutic group home.
   c) A therapeutic foster care program.
   d) Day treatment centres.
   e) Crisis intervention centres.
   f) Respite care for the parents of the handicapped.

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Chapter X

BOOMS, BUSTS, SUICIDE

Rapid alterations in the economic scene, reports of a possible epidemic of adolescent suicide: our system of mental health and related services for young people is constantly being stressed. This brief chapter deals with the changing nature of the demands we can expect to be made on that system. The subsequent chapter will focus on the education and training we need to improve the ability of that system to meet such demands in a flexible manner.

Economic Booms and Busts

During the two year course of this Study, economic predictions for our Province have ranged from an imminent oil or natural gas boom to a prolonged depression with very high unemployment rates. Whatever may befall us, rapid socioeconomic change of any kind will bring with it an increased need for social and mental health services for all age groups and for young people in particular.

Booms

When a region enjoys a resource boom it naturally draws to it many newcomers, skilled and unskilled. Families may or may not accompany these newcomers but any move—with its unfamiliar neighborhood, loss of contact with old friends and neighbors, separation from relatives, new schools for children—stresses both individuals and families and thus increases the need for mental health and social services. Rates of mental illness, suicide, crime, and divorce are likely to increase.[1] Families already living in the boom region must cope with an influx of newcomers, changed traffic patterns and new construction, and frequently, greatly increased housing costs. Again, the stress is likely to increase the need for social and mental health services: not exclusively for children and adolescents, of course, but certainly for these age groups as well.

"Busts"

Economic booms frequently end in economic busts, either immediately after the new construction phase or when the original resources have been depleted. But "busts" also can result from world-wide economic recessions and depressions, with their attendant very high rates of unemployment. This unemployment affects mental health and social services in three ways. First, the loss of income stresses families and individuals (including their children) and so increases the need for services. Second, loss of employment means for many people the loss of much of their social identity and self-esteem, their feelings of worth—and once again stresses the family and individuals. For young people in particular, high unemployment rates mean that they may not be able to find even a first job, growing alienated and angry and again increasing the need for services. Finally (third), high unemployment typically means that, unlike the boom time, the resources available to both government and private charity are greatly reduced, resulting in cut-backs in social and mental health services precisely when these are most needed. Here, perhaps, is the main difference between economic booms and busts for mental health and social service planning: during booms both demand and resources increase, while during busts only demand increases while resources diminish.

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[1] Information on the effects of booms derives from discussion with Prof. L. Kasdan of Dalhousie University's Department of Sociology and Social Anthropology and from Davenport and Davenport (1979).

Suicide

Is Canada experiencing a wave of adolescent suicide? Studies based on Alberta Vital Statistics suggest, for that province at least, that suicide among young people is occurring with increasing frequency (Hellon and Solomon 1980, Solomon and Hellon 1980). In response to growing concern over the suicide rate, in 1981 the Alberta provincial government granted the Canadian Mental Health Association $129,000 for a suicide information program and $68,000 for educational services, resulting in the formation of the Calgary-based Suicide Information and Education Centre. Studies conducted in the United States suggest that there, too, adolescent suicide appears to be on the increase (Holinger 1978, Holinger and Offer 1982, Murphy and Wetzel 1980).

In Nova Scotia, during 1981, there were newspaper accounts (apparently based on RCMP sources) of an alleged rash of adolescent suicides in Queens County. But tables 41 and 42 show no substantial differences between the overall Nova Scotia suicide rate and that of Canada as a whole or between Nova Scotia and the other Maritime Provinces. Nor do the tables reveal any unusual adolescent suicide problem for any one of Nova Scotia's counties, including Queens County.

Unfortunately, Vital Statistics suicide data for any age group are unreliable: how can we know how many single-vehicle or drug over-dose fatalities were or were not suicide, for example? Data on child and adolescent suicide are even less likely to be valid, for what examining physician wishes to tell parents that their child took his or her own life? Indeed, some physicians even argue that child suicide is an impossibility, given that a child can have no real awareness of the permanence of death.

These philosophical issues aside, a new study, based on admissions to a major Toronto pediatric hospital, does suggest that child and adolescent suicide is, after all, a serious problem in Canada (Garfinkel, Froese and Hood 1982). And a Swedish follow-up of 2,164 children originally seen at the Stockholm Municipal Child Guidance Clinic during 1953-55 found that 37 of the group had died violently. Nine of these "in all probability suicided while

Table 41 Suicide Rates per 100,000 Population, by Age Group and Sex, for the Maritime Provinces and Canada, 1979, 1980[1]

	NOVA SCOTIA						NEW BUNSWICK					
	1979			1980			1979			1980		
AGE GROUP	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
0-9	-	-	-	-	-	-	-	-	-	-	-	-
10-14	2.6	-	1.3	-	-	-	-	-	-	-	-	-
15-19	17.7	4.6	11.3	15.6	-	8.0	31.1	2.7	17.3	10.4	-	5.4
All ages	21.1	4.0	12.5	20.5	2.3	11.4	21.1	2.9	12.0	20.1	2.8	11.4

	PRINCE EDWARD ISLAND						CANADA					
	1979			1980			1979			1980		
AGE GROUP	Male	Female	Both	Male	Female	Both	Male	Female	Both	Male	Female	Both
0-9	-	-	-	-	-	-	-	0.06	.03	-	-	-
10-14	-	-	-	-	-	-	1.5	0.7	1.1	1.5	0.6	1.1
15-19	14.7	-	7.5	29.0	-	15.0	21.1	4.8	12.9	19.8	3.7	11.8
All Ages	21.0	4.9	13.0	20.8	1.6	11.3	21.3	7.1	14.2	21.2	6.9	14.0

1. Data were supplied by Statistics Canada.

Table **42** Suicide in the 0-20 Age Group, by Sex, for Each County, 1980, 1981, 1982[1]

AGE GROUP		ANNAPOLIS COUNTY			ANTIGONISH COUNTY			CAPE BRETON COUNTY			COLCHESTER COUNTY		
		Male	Female	N	Male	Female	N	Male	Female	N	Male	Female	N
15 and under	1980	–	–	–	–	–	–	–	–	–	–	–	–
16 - 20		1	–	1	–	–	–	1	–	1	1	–	1
Total		1	–	1	–	–	–	1	–	1	1	–	1
15 and under	1981	–	–	–	–	–	–	–	–	–	–	–	–
16 - 20		–	1	1	–	–	–	1	–	1	–	–	–
Total		–	1	1	–	–	–	1	–	1	–	–	–
15 and under	1982	–	–	–	–	–	–	–	–	–	1	–	1
16 - 20		–	1	1	–	–	–	–	–	–	–	–	–
Total		–	–	–	–	–	–	–	–	–	1	–	1
(To June 30)													

(Continued)

Table 42 (Continued)

AGE GROUP		CUMBERLAND COUNTY			DIGBY COUNTY			GUYSBOROUGH COUNTY			HALIFAX COUNTY		
		Male	Female	N	Male	Female	N	Male	Female	N	Male	Female	N
15 and under	1980	-	-	-	-	-	-	-	-	-	-	-	-
16 - 20		-	-	-	-	-	-	-	-	-	3	-	3
Total		-	-	-	-	-	-	-	-	-	3	-	3
15 and under	1981	-	-	-	-	-	-	-	-	-	-	-	-
16 - 20		-	-	-	1	-	1	-	1	1	2	2	4
Total		-	-	-	1	-	-	-	1	1	2	2	4
15 and under	1982	-	-	-	-	-	-	-	-	-	-	-	-
16 - 20		-	-	-	-	-	-	-	-	-	2	1	3
Total		-	-	-	-	-	-	-	-	-	2	1	3
(To June 30)													

(Continued)

ble 42 (Continued)

GE GROUP		HANTS COUNTY Male	HANTS COUNTY Female	HANTS COUNTY N	INVERNESS COUNTY Male	INVERNESS COUNTY Female	INVERNESS COUNTY N	KINGS COUNTY Male	KINGS COUNTY Female	KINGS COUNTY N	LUNENBURG COUNTY Male	LUNENBURG COUNTY Female	LUNENBURG COUNTY N
5 and Under	1 9 8 0	-	-	-	-	-	-	-	-	-	-	-	-
6 - 20		-	-	-	1	-	1	-	-	-	-	-	-
otal		-	-	-	1	-	1	-	-	-	-	-	-
5 and Under	1 9 8 1	-	-	-	-	-	-	-	-	-	-	-	-
6 - 20		-	-	-	-	-	-	1	-	1	1	-	1
otal		-	-	-	-	-	-	1	-	1	1	-	1
5 and Under	1 9 8 2	-	-	-	-	-	-	-	-	-	-	-	-
6 - 20		-	-	-	-	-	-	1	-	1	-	-	-
otal			-	-	-	-	-	1	-	1	-	-	-
To June 30)													

(Continued)

Table 42 (Continued)

AGE GROUP		PICTOU COUNTY Male	PICTOU COUNTY Female	PICTOU COUNTY N	QUEENS COUNTY Male	QUEENS COUNTY Female	QUEENS COUNTY N	RICHMOND COUNTY Male	RICHMOND COUNTY Female	RICHMOND COUNTY N	SHELBURNE COUNTY Male	SHELBURNE COUNTY Female	SHELBURNE COUNTY N
15 and under	1980	-	-	-	-	-	-	-	-	-	-	-	-
16 - 20		-	-	-	1	-	1	-	-	-	-	-	-
Total		-	-	-	1	-	1	-	-	-	-	-	-
15 and under	1981	-	-	-	2	-	2	-	-	-	-	-	-
16 - 20		-	-	-	1	-	1	-	-	-	-	-	-
Total		-	-	-	3	-	3	-	-	-	-	-	-
15 and under	1982	-	-	-	-	-	-	-	-	-	-	-	-
16 - 20		-	-	-	-	-	-	-	-	-	-	-	-
Total		-	-	-	-	-	-	-	-	-	-	-	-
(To June 30)													

(Continued)

Table 42 (Continued

AGE GROUP		VICTORIA COUNTY Male	Female	N	YARMOUTH COUNTY Male	Female	N	ROW TOTALS Male	Female	N
15 and under	1980	-	-	-	-	-	-	-	-	-
16 - 20		-	-	-	-	-	-	8	-	8
Total		-	-	-	-	-	-	8	-	8
15 and under	1981	-	-	-	-	-	-	2		2
16 - 20		-	-	-	-	-	-	7	4	11
Total		-	-	-	-	-	-	9	4	13
15 and under	1982	-	-	-	-	-	-	1	-	1
16 - 20		-	-	-	-	-	-	3	2	5
Total		-	-	-	-	-	-	4	2	6

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1. Data were kindly supplied by the Deputy Registrar General of the N. S. Department of Health, Donald F. Arthur.

suffering from mental ill-health," since "grave psychopathological symptoms had already been diagnosed in all of these in connection with their contacts with the CGC" (Nylander 1979:14). In short, at least some of the troubled young people seen at mental health facilities are at risk of death by suicide.

A major research project to establish the extent to which child and adolescent suicide is a serious problem in Nova Scotia could cost almost as much as would a modest suicide prevention program. While research is indeed needed, for the present we should assume suicide of young people is a real problem and then establish policies to deal with it. For example, child psychiatrists increasingly argue that childhood depression is a serious, treatable, but frequently undiagnosed illness. Some argue that adolescent suicide may be the outcome of untreated childhood depression. This Study recommends that increased continuing medical education be made available to family practitioners to improve their ability to identify mental health problems in general among children, with special emphasis on depression.[2] The Study further recommends that the staff of Youth Health Centres receive similar continuing education. In addition, YHC staff must be trained to recognize and cope with suicidal tendencies in young people. Finally, Local Committees should give a high priority to the crisis intervention and emergency psychiatric facilities discussed in chapter IX ("Special Facilities").

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[2] Table 27 (chapter IV) shows that only 1.2 percent of age 0-19 mental health out-patients are diagnosed as depressive. If depression is indeed a common problem among Nova Scotia's young people then it is certainly going unrecognized.

Summary of Chapter X, "Booms, Busts, Suicide"

1. During economic booms, demand for social and mental health services rise sharply.

2. During economic "busts" or recessions/depressions, social and mental health problems are different but the demand for services also rises. (The chief difference is that, unlike during "boomtime" the economic resources to provide the needed services are likely to be missing.

3. The chief bottlenecks to coping with rapid economic change and resulting demand for services are not primarily financial but staff-related. Recommendations dealing with staff shortages and with training facilities and continuing education (in chapters II and XI) are therefore doubly important.

4. There is reason to believe that child and adolescent suicide may be a growing problem in Nova Scotia and elsewhere.

5. Therefore, continuing medical education should be made available to family practitioners to improve their ability to identify mental health problems in general among children with special attention to depression (since childhood depression may be a precursor to suicide).

6. The staff of Youth Health Centres should receive similar continuing education.

7. YHC staff must be trained to recognize suicidal tendencies in young people.

8. Local Committees should give a high priority to the crisis intervention and emergency psychiatric services suggested in chapter IX.

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Chapter XI

EDUCATION AND TRAINING

Education and training are not panaceas but in the absence of miracles they must serve. Education and training can help solve at least three sets of problems. First, they can remedy the absolute shortage of professionals with expertise in children and adolescents. Second, they can vary the mix of existing skills among these professionals so as to meet changing needs (the need for flexibility discussed in the previous chapter). Third, they can alleviate the problems of professional rivalry discussed in chapter II.

Professional Training

As was discussed in chapter II, the shortage of mental health and related specialists trained to deal with children and adolescents is continent-wide. Nova Scotia is at an additional disadvantage, for even the Metro area is spurned by some in favor of larger urban areas such as Toronto or Vancouver. The non-Metro areas of the Province, despite their beauty, suffer even more: their facilities tend to lack the "critical mass" of personnel that highly trained staff often find necessary to prevent feelings of isolation from the mainstream of their disciplines. Yet, there is no point in planning for changing socioeconomic circumstances--or even for bringing all parts of the Province up to a minimum level of services—if skilled manpower is unavailable.

There is no reason Nova Scotia should not be training all the professionals it needs. Dalhousie University's Faculty of Medicine trains a full range of physicians, including child psychiatrists and pediatricians. The Maritime School of Social Work trains social workers at both the BSW and MSW levels. Dalhousie University's Department of Psychology has a doctoral-level program in mental and clinical psychology in its early stages and its staff includes both developmental and clincal psychologists. Nevertheless, Nova Scotia suffers from severe shortages of psychiatrists, psychologists, and clinically oriented social workers with particular expertise in children and adolescents. Why should this be so?

There are three problems: (1) The professionals trained do not necessarily remain in the Province. (2) The training programs do not always receive sufficient financial support. (3) The professionals that are being trained may not meet the needs of the health and social service agencies that require them.

To begin with the last, this problem is true more for social work than for the other needed professions. The Maritime School of Social Work does not stress clinical training and has no plans to do so: such training in the MSW program is available only if an appropriate elective happens to be offered (none was offered, during 1982-83) or if a student chooses a field placement at (for example) the Atlantic Child Guidance Centre. There is little specialized material in the curriculum dealing specifically with children and adolescents, though one stream in the MSW program is in "family functioning." However, mental health and social service personnel throughout the Province complained of the scarcity of MSW-level social workers with clinical skills and special training in the problems of young people. They spoke of the necessity of recruiting out-of-Province. This Study recommends that an early task of the Staff of the Youth Secretariat be to discuss the curriculum planning policies of the Maritime School of Social Work with that School's officials and if necessary to make appropriate recommendations to the Secretariat to ensure that the MSW produces social workers who meet the needs of the Province's mental health, social service, and educational facilities.

The second problem, that of financial support, is the major hurdle in the production of clinical psychologists in Nova Scotia. For the programs at Dalhousie University and at St. Mary's University, the recommendation is clear: Greater financial support must be provided for the training of clinical psychologists, with special emphasis on support staff with special expertise in the problems of children and adolescents.

The problem of personnel being trained in Nova Scotia and then taking their skills elsewhere affects all three professions. For child psychiatry, social work and clinical psychology, bursaries are available which obligate a newly qualified professional to remain in the Province. It is urged that this scheme be publicized and made known to university students and others, and that the amounts provided be competitive with bursaries elsewhere. At present, bursaries for non-psychiatric fields are grossly insufficient. It is further urged that special effort be made to provide bursaries to students from non-Metro areas of the Province who indicate that they wish to return to their own communities to practice their professions. It is suggested that admissions committees in the appropriate institutions consider giving preference to such students. Finally, it is recommended that, as part of their training, students in all three professions spend varying periods in mental health and social service facilities in non-Metro areas, both to familiarize themselves with non-Metro problems as part of their training and in the hope that some will choose to return to non-Metro facilities to practice their professions. It is also recommended that agencies hiring professionals with scarce skills in the problems of children and adolescents be unusually generous in paying for attendance at professional meetings and in meeting the costs of journal subscriptions, especially when the agencies in question are outside the Metro area. Staff members should be permitted "sabbatical" time for additional training and funding agencies should provide replacement for staff on educational sabbatical. The goal here is to reduce the feeling of being out of the mainstream professionals in smaller and more isolated facilities complain of, and to encourage them to remain abreast of current developments in their various fields.

Continuing Education

Professionals need more than encouragement to remain abreast of current developments--they need courses and seminars. The Atlantic Child Guidance Centre provides a range of such courses annually. For 1982-83, the courses offered (on a fee basis) included:

a. Using the new diagnostic system for emotional disorders
b. Child psychodiagnostics
c. Anorexia Nervosa and Bulimia
d. Theoretical and Conceptual Underpinnings of Family Therapy
e. Structural Family Therapy Training: Level I
f. Structural Family Therapy Training: Level II
g. Structural Family Therapy Training: 7 month extership
h. Rational-emotive psychotherapy: Levels I and II

It has already been recommended in chapter VIII "(Special Problems of the Metro Area") that the ACGC continue to offer such courses. It is recommended that the Staff of the Youth Secretariat monitor and coordinate the offering of such courses and seminars throughout the Province, and bring to the attention of the appropriate facilities and universities any continuing education opportunities which appear to be needed but lacking. This Study specifically recommends the following courses:

1) For juvenile protection (probation) workers and family court judges, a seminar on when clinical assessment and/or treatment are appropriate and what can realistically be expected of them.

2) For junior levels of staff at both hospital and non-hospital residential facilities, seminars and training programs in the problems of children and adolescents, in behavior and other forms of therapy, and in case management.

Finally, it was noted in chapter VIII that the Atlantic Child Guidance Centre was (at the time of this writing) planning a "court clinic" to provide mental health advice and services to family court judges and staff pertaining to young people who have come to the attention of the courts. Assuming this court clinic is established, it is recommended that the ACGC rotate at least one staff member from every YHC in the Province through this court clinic as an educational measure. Thus, all YHCs would eventually have a staff member with special expertise in aiding the courts.

ontinuing Medical Education

It is a cliché to note that most psychiatry is practiced not by psychiatrists but by family practitioners. A British study, for example, found that while only 3.5 percent of general practitioners' child and adolescent patients were suffering from psychological complaints, 25.7 percent had a psychological component to the presenting problem (Bailey, Graham and Boniface 1978). Informal interviews with Nova Scotia family practitioners and pediatricians provided physicians' "guestimates" of five to twenty percent of young patients suffering primarily or secondarily from "emotional" problems. The MSI data discussed in chapter IV suggest that some categories of patients—adolescent females in particular—are much more likely than others to receive diagnoses of mental disorder.

Family practitioners interviewed either received favorably the idea of additional continuing medical education in child and adolescent psychiatry or else made the suggestion themselves. A frequent response to a question about the amount of childhood depression they saw, for example, was an indication of doubt as to their ability to recognize this condition. Pediatricians and child psychiatrists agreed even more strongly than family physicians that increased continuing medical education in child psychiatry and related child behavior fields should be made available to physicians throughout the Province. They added to this the strong recommendation that continuing medical education in the field of learning disabilities also be made available.

Though no objective data were collected concerning the extent to which Nova Scotia family physicians are able to keep abreast of developments in child psychiatry and related fields, it is worth noting that an American study found that physicians were more likely to note a mother's concern about a child's physical health problems than they were her remarks about behavioral or mental problems (Starfield and Borkowf 1969). Many mental health professionals believe that most chronic problems have their inception during the child's earliest years and that the younger the child the more likely is therapeutic intervention to be effective. Parents tend to rely on their family physician when their child's behavior has made them anxious so it is vital that he or she be able to recognize potentially serious problems. This Study recommends increased continuing medical education for Nova Scotia's family physicians in child psychiatry and related fields, with particular emphasis on diagnosis and on learning disabilities.[1]

Interdisciplinary Training

Chapter II discussed the problem of disciplinary rivalries among mental health professionals. Many physicians have not been trained to collaborate with clinical and development psychologists, with social workers, and with other professionals likely to have expertise in the problems of young people. But meeting rapidly changing socioeconomic conditions--or simply providing adequate service in general—requires that all professionals be able to cooperate with one another on the child's behalf.

Part of the problem is one of prejudice: some non-medical professionals interviewed were clearly biased against physicians, viewing them as poorly qualified to provide most mental health services but as nevertheless demanding control over (and higher remuneration for) treatment programs. In similar fashion, some physicians argued that doctoral-level psychologists were less acceptable to them than those with lower qualifications, while several physicians were unaware that their referring to fellow professionals as "ancillary" personnel revealed their lack of respect to all concerned (since, in many cases, it is the physician whose role is ancillary and it is the behavioral psychologist or family therapist social worker whose skills are pertinent). In a number of cases, however, the problem was one not of prejudice but of honest ignorance on the part of physicians, who (for example) often were unaware that sociologists and social workers belong to entirely different professions, or that there are many types of both social workers and psychologists and these types are by no means interchangeable when specific clinical skills with particular age groups are required. In particular, family physicians tend to refer to psychiatrists patients actually in need of social workers (or of other nonmedical professionals).

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[1] These recommendations were informally discussed, prior to the conclusion of the Study, with Dr. Wayne Putnam of Dalhousie University's Department of Continuing Medical Education.

The solutions to these problems involve multidisciplinary training. First, to the extent feasible, future specialists in the problems of children and adolescents should receive portions of their training jointly. The intent here is to foster mutual respect through shared training experience. Since in Nova Scotia a single institution—Dalhousie University—trains child psychiatrists, pediatricians, family practitioners, nurses, occupational therapists, psychologists and social workers, this Study recommends to that University that it review its curricula for these varied professions in order to include as many joint seminars and courses as possible. The Staff of the Youth Secretariat must periodically review the extent to which it has proved possible to implement this recommendation and report its findings to the Secretariat.

Second, it is also recommended to Dalhousie University that the training of each of the professions providing mental health and related services to children and adolescents include specific education in the capabilities of their sister professions, in order to ensure that future cooperation is not prevented by ignorance. Since most mental health and related professionals have already been trained, however, an additional recommendation, concerning continuing medical education, is necessary: Continuing medical education should be made available to Nova Scotia's physicians on the skills of psychologists, social workers, community health nurses, and other mental health/social service professionals. Ideally, this continuing education should be available to non-medical as well as medical professionals.

Finally, chapter VIII ("Special Problems of the Metro Area") recommended that the Atlantic Child Guidance Centre maintain a close relationship with the Department of Psychiatry of the I.W.K. Hospital and play a special role in the training of professionals concerned with the problems of children and adolescents. This recommendation is especially appropriate because the ACGC is an example of a successfully multidisciplinary facility. This chapter therefore expands that recommendation: The ACGC and Dalhousie University should enter into a formal relationship whereby the ACGC setting and staff play a substantial role in the training of mental health and related professionals (e.g., family practitioners, psychiatrists, psychologists, social workers, occupational therapists, educational personnel, nurses, etc.) who will be concerned with the problems of children and adolescents.

Summary of Chapter XI, "Education and Training"

1. Staff with expertise in the problems of children and adolescents is in short supply everywhere. In Nova Scotia, there are three aspects of this problem: a) trained staff often leave the province; b) training programs do not always receive sufficient financial support; and c) the professionals trained may not meet the needs of the health and social service facilities that require them.

2. Since this last problem is chiefly true of social work, it is recommended that an early task of the Staff of the Youth Secretariat be to discuss the curriculum planning policies of the Maritime School of Social Work with that School's officials and if necessary to make appropriate recommendations to the Secretariat to ensure that the Maritime School of Social Work produces social workers who meet the needs of the Province's mental health, social service, and educational facilities.

3. Since some training programs are not receiving sufficient support to produce the needed professionals, it is here recommended that clinical psychology programs at St. Mary's University and Dalhousie University be fully funded, with special emphasis on support staff with expertise in the problems of children and adolescents and on training doctoral-level clinical psychologists.

4. In order to recruit and retain professionals, it is recommended: (a) that wide publicity be given to the existing system of bursaries in child psychiatry, social work and psychology acceptance of which obligate individuals to remain in the Province for a specified period; (b) that the sums provided by these bursaries be increased to and maintained at levels at which they attract students. This is particularly necessary for fields other than psychiatry (since bursaries for these professions are now so low as to be almost token in nature); (c) that admissions committees of training programs pay special attention to applicants from parts of the Province badly in need of skilled professionals, provided those applicants indicate a desire to return to their own regions to practice their new professions; (d) that students in psychology, social work and psychiatry as part of their training spend varying periods of time in mental health and social service facilities in non-Metro areas, both to familiarize themselves with non-Metro problems and in the hope that some will choose to return to non-Metro facilities to practice their professions; (e) that in an additional effort to attract and retain professionals, mental health and other facilities responsible for children and adolescents should be generous in paying for attendance at professional meetings, paying for journal subscriptions, and permitting "sabbatical" time for additional training, the goal of these measures being to reduce the feelings of professional isolation of which staff often complain.

5. The Youth Secretariat is to have responsibility for the monitoring and coordinating of continuing education courses for mental health, social service and educational staff who serve children and adolescents.

6. The ACGC now offers a variety of continuing education courses of this nature and should continue to do so.

7. When needed continuing education courses are not being offered it is the responsibility of the Youth Secretariat Staff to bring this lack to the attention of the appropriate facilities and universities.

8. This study specifically recommends the two following courses:

   a) For special protection (juvenile probation) officers and family court judges, a seminar on when clinical assessment and/or treatment are appropriate and what can realistically be expected of them.

   b) For junior levels of staff at both hospital and non-hospital residential facilities, seminars and training programs in the problems of children and adolescents, in behavior and other forms of therapy, and in case management.

9. Dalhousie University's Department of Continuing Medical Education should make available to the Province's family practitioners continuing medical education in the following area:

   a) Diagnosis and assessment of children's and adolescents' mental disorders, with special reference to depression and learning disabilities, and autism.

10. Given the belief that multidisciplinary training mitigates the problems of rivalries and misunderstandings across the helping professions which provide services to children and adolescents; and given that in Nova Scotia a single institution, Dalhousie University, trains child psychiatrists, pediatricians, family practitioners, nurses, occupational therapists, psychologists and social workers: this Study recommends to the University that it review its curricula for these varied professions as soon as possible in order that as many seminars, courses and experiences as possible be shared. The Staff of the Youth Secretariat must periodically review the extent to which this recommendation has been implemented and report its findings to the Youth Secretariat.

11. It is also recommended to Dalhousie University that the training of each of the professions providing mental health and related services to children and adolescents include specific education in the capabilities of their sister professions.

12. In similar fashion, continuing medical education should be made available to Nova Scotia's physicians on the skills of psychologists, social workers, community health nurses, and other mental health/social service professionals. Ideally, this continuing education should be available to non-medical as well as medical professionals.

13. The Atlantic Child Guidance Centre and Dalhousie University should enter into a formal arrangement whereby the ACGC's setting and staff play a substantial role in the training of mental health and related professionals (e.g., family practitioners, psychiatrists, psychologists, social workers, occupational therapists, special education teachers, guidance counselors, nurses, etc.) who will be concerned with the problems of children and adolescents.

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Chapter XII

CONCLUSIONS AND RESEARCH

The major thrust of this Study has not been to discover what services our children need. We already knew that—or at least, the members of the Commission on Emotional and Learning Disorders in Children did, and their most pertinent recommendations constitute appendix ii of this report. What we did not know, in Nova Scotia, was how to implement those recommendations, that is, how to meet our children's needs.

And so it was decided that Once More For Chidren would not be "one more study" of needs assessment, one additional study concluding that what we need is "more". Instead, the "needs assessment" material was relegated to an appendix (appendix iii) and the focus moved to structure and process. It was necessary to understand why, despite our knowledge, young people were still being poorly served. Chapter II summarizes that understanding, and other chapters propose ways of organizing and administering services so that the problems identified can be overcome. The emphasis has been on process, not so much on solving specific difficulties once-and-for-all, but on setting in motion on-going processes that will help to resolve a broad range of difficulties each time they arise.

The Local Committees, for example, in part are intended as arenas for combat, as forums in which various interest groups can communicate, debate, and with the help of outside experts and mediators—Secretariat Staff—achieve consensus. At the same time, the Local Committees also constitute permanent pressure groups, lobbies for children's services with the Secretariat Staff their conduit to the highest levels of provincial government.

It is not clear whether all this will work. Once More For Children not only calls for research evaluation of the effectiveness of our mental health interventions in the lives of young people: it also calls for an evaluation of its own recommendations. Chapter V recommends a study, some four years after the implementation of the "Youth Secretariat/Local Committee Model", to determine if this reorganization has succeeded in achieving its specified goals. If it has not then the best alternative may well be the creation of a new "department of child/youth services".

Research & Evaluation

The discovery of ignorance was the most dismaying finding of this Study. Even more saddening than the pleas of parents of handicapped children for respite services, more saddening than reports of school principals who permit special education classes filled with hyperkinetic children to be perpetually disrupted by the ringing of bells and clamoring of a public address system,[1] was the realization of how few of our interventions, how few of our preventive programs, and how few of our priorities are based on empirical knowledge. We do not know what works and we do not know what does not work. We rely on the training and experience and biases of our professionals, but the fact that their wisdom changes from decade to decade does not inspire confidence. As chapters III and VII urge, Nova Scotia's young people need programs designed to be evaluated, with the results of their eventual evaluations fed back into the planning and setting of priorities process.

All research on problems of and services for children and adolescents must follow two guidelines: independence and context. By "independence" is meant the rule that neither individuals nor agencies or departments should evaluate their own programs. Evaluation must be external. Where facilities choose to organize their own "in-house" evaluation efforts these should never be permitted to replace external evaluation. The problem is not only one of objectivity but of expertise. It is unusual for individuals trained primarily as clinicians also to be expert in the specialized research skills needed to conduct evaluation. (Unfortunately, it is not unusual for clinicians to convince themselves that because they can provide a treatment they can also evaluate it.

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[1] These are the kinds of problems which, in the future, must be brought to Local Committees.

"Context" is the second guideline: programs are to be evaluated in the context of the total network of services rather than in isolation. One way to emphasize the importance of context is to discuss how the efficiency, outcome effectiveness, and appropriateness of a treatment program or facility all depend both on each other and on the surrounding network of services.[2]

For example, evaluation of mental health services most often is restricted to efficiency. Administrators and accountants are likely to limit themselves to readily available statistics on total number of patients or clients seen or average number of contacts per staff member. But excellent fuel economy is pointless if the car is speeding in the wrong direction. What would be served by an efficiently provided program that only occasionally worked, that is, was low on treatment effectiveness? Or by an effective program that reached only a few percent of those needing it? In similar fashion, a program which is both effective and efficient may fail because it is inappropriate: a screening program for a particular disability provided in a reliable and efficient manner but not linked to a remediation program would be inappropriate. Another example: how appropriate would it be for a facility to devote its efforts to counselling the children of lone parents while providing no treatment services for the severely disturbed or the learning disabled? Here, the context guideline has to do with priorities.

Chapter VIII already discusses the importance of scientific research for rational planning and evaluation. The topic is returned to here, in this final chapter, in order to emphasize its extreme importance and to discuss ways of ensuring that the needed research actually does take place.

It is the Youth Secretariat and its Staff who are charged with seeing that necessary research is done. In the expectation that financial constraints will eventually ease, this Study recommends that the Secretariat follow one or more of the following (not mutually exclusive) options: (a) providing grants to researchers; (b) letting contracts for research; and (c) creating its own research and evaluation capability. Regardless of which option is selected, Youth Secretariat Staff must have the sophistication to know what research is needed, and to interpret its results once it has been completed.

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[2] I am grateful to Dr. L. Denton for this tripartite conceptualization of evaluation.

Option for Program Research 1: Grants to Researchers

Nova Scotia should, when budgetary constraints ease, follow the example of Ontario. In 1982, the Province of Ontario made available some $400,000 in provincial lottery funds for research involving children's services. Acceptable research areas were day care, child welfare, juvenile corrections and detention, mental health, and developmental handicaps. Grant applications were required to have an applied orientation with the two highest priorities given to primary prevention and intervention evaluation.[3] Grants were awarded on a competitive basis.

In Nova Scotia, until financial constraints do ease, Secretariat Staff in the absence of funds must rely on persuasion and access to data to encourage researchers to provide the studies so badly needed for planning. There is no doubt that our Province has researchers with the required skills, both inside and outside the universities. To give a small number of examples (and with no intention of slighting those not named), a paper recently (1982) presented by Dr. L.R. Denton of Atlantic Behavioural Science Applications (Truro) deals with "planning and evaluating community health programs". Dr. Matthew Spence, Director of the Atlantic Research Centre for Mental Retardation, has been conducting evaluation research on a program to prevent developmental disability through prenatal care. Prof. Cameron McQueen of Dalhousie University's Department of Preventive Medicine is conducting a study assessing the services received by pre-school mentally retarded children. Secretariat Staff should encourage such research efforts by suggesting topics and projects to researchers, facilitating access to data, and presenting would-be researchers to members of Local Committees in order that a basis for cooperation be established.

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[3] Children's Services, Ontario Ministry of Community and Social Services, vol. 6, no. 3, March/April 1982, pp. 6-7.

Option for Program Research 2: Contracts

Secretariat Staff should have funding to let evaluation contracts to private firms. So long as the previously discussed two guidelines are followed, and so long as either Staff (or a consulted member of the academic community) confirms that a firm has the necessary expertise and is following a scientifically appropriate research plan, private enterprise can certainly meet the need for evaluation of services for young people.

Option for Program Research 3: A Provincial Research Team

As of this writing, the Department of Health's capability for conducting evaluation research appears to be limited. Experienced professionals, ordinarily at the doctoral level, are required for the kinds of research called for in Once More For Children. Creating such a team would be a major expense and could be justified only if it served not just all age groups but all government departments.

Multiproblem Families

One final research topic requires concluding emphasis, that of the "multiproblem families" discussed in chapter II. A major British study (Rutter and Madge 1976) confirmed what experienced social service and community health personnel already know: much deviant behaviour, including mental illness, is a product of the troubled raising troubled children. Children of former mental disorder patients, for example, were found by Rutter and Madge to be twice as likely as were controls to suffer from "persisting emotional and behavioural difficulties" (1976:200). Children diagnosed as having conduct disorders tended to have one parent who had a "broken home" (p. 205).

Multiproblem families often live in "depressed area" communities, usually well known to social service and community health workers.[4] Such communities, along with the multiproblem families dwelling apart from them, need a concerted government effort, a "preventive" effort to break the generational transmission of tragedy. No one agency or even department has either the resources or the responsibility, and many of the underlying problems are economic. Once More For Children therefore recommends that the Youth Secretariat take the initiative in seeing that a multi-department task force be set up with the goals of:

a) identifying the pockets of multiproblem families throughout the province;
b) targeting specific communities as "pilot projects";
c) designing a long-term plan for breaking the generational transmission of problems by concentrating the energies of all relevant "helping" agencies on the well-being and welfare of the children;
d) specifying goals in terms of which the project may be evaluated in the future;
e) carrying out the plan and subsequently arranging for its evaluation;
f) choosing new targets and starting all over again.

Concluding Remarks

As families, many of us have decided to share love with a smaller number of children than our grandparents did. Who is to say, though, that the total amount of our love has diminished? The 0-19 age group is declining as a proportion of our total population—that was pointed out back in chapter IV. But who is to say that the services we provide for our young people must therefore also diminish?

During meetings of the Advisory Committee, it was often remarked that we were moving into a period of enhanced concern for our elders, for the seniors and not for the young. It was anticipated that expensive recommendations were unlikely to be instantly implemented. But our children are our future seniors. So are we, and we will be seniors first. And when we—the writers and most of the readers of reports like this one--reach senior status, who will be the workers whose taxes support us, the professionals who serve and care for us? Why, those who today are our children, of course. If we turn away from them now, by what right do we ask their aid in the future?

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[4] Hughes et al. (1960), remain an excellent discussion of depressed areas and social disintegration in Nova Scotia. See especially pp. 295-308.

Summary of Chapter XII, "Conclusions"

1. This Study has emphasized why, despite past reports and their wise recommendations, problems have persisted. Thus, the thrust of the recommendations has not been so much to increase services--though that, too, must be done—as to create structures and processes which will result in the continuing creation (and repair) of a system of services for young people in all parts of the Province.

2. The most dismaying finding of the Study has been the paucity of hard research data upon which to base decisions and set priorities. Thus, the recommendations have emphasized program research and evaluation.

3. The Youth Secretariat is charged with ensuring that needed program research and evaluation takes place. The Secretariat should follow one or more of the following options:
   a) Providing grants on a competitive basis to researchers for needed research and evaluation of services.
   b) Letting contracts to private firms for the needed research and evaluation.
   c) Maintaining a cross-department research capacity.

4. In the absence of funding, Secretariat Staff must rely on persuasion and access to data to encourage researchers to provide the studies so badly needed for planning.

5. Multiproblem families remain a major but un-targeted problem in that they provide a substantial portion of our social service and mental health clientele, often the same families reproducing problems from generation to generation. This Study therefore recommends a multi-department task force be established with the goals of:
   a) identifying the pockets of multiproblem families throughout the Province;
   b) targeting specific communities as "pilot projects"; and
   c) designing a long-term plan for breaking the generational transmission of problems by concentrating the energies of all relevant "helping" agencies on the well-being and welfare of the children.

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APPENDIX i

PROPOSAL FOR PROVINCE WIDE STUDY OF CHILDREN'S SERVICES WITH SPECIAL EMPHASIS ON PSYCHIATRIC AND RELATED PROGRAMS AS PROVIDED BY THE NOVA SCOTIA DEPARTMENT OF HEALTH.

INTRODUCTION

In response to an invitation in his letter dated January 12, 1979 from the Honourable Gerald Sheehy, Minister of Health of Nova Scotia, the Metropolitan Mental Health Planning Board presents herewith terms of reference for a study which under supervision of a special committee would consider those services for children and youth, specifically provided by the Department of Health, throughout the province. The thrust of the study would relate to psychiatric mental health services with an appropriate reference to programs related to these services some of which are provided by the Departments of Education and Social Services. For this reason the Minister of Health in his letter of May 30, 1979 authorized the board to request representation on the committee from these other two departments. The board acknowledges the assistance of the Association of Mental Health Staffs of Nova Scotia which appointed three representatives to a group which assisted in the preparation of these terms of reference. The same appointees along with others mentioned in this proposal are prepared to continue as a steering committee, supervising the proposed study which would be conducted by a qualified principal investigator.

RATIONALE AND GOAL

Because of the widespread and high interest generated by the International Year of the Child, because of world wide increase in psycho-social problems of children and youth (an elaboration on which will be presented in the proposed report) and because there is need for the board's previous report on metropolitan children's services to be expanded to include all areas of the province, the board, in response to the suggestion by the Minister, has endorsed the idea of there being a province wide study of services for children and youth. The overall goal of this study would be to determine the needs for the target group and, in the light of these findings, indicate priorities and provide a blue print for the development and delivery of services required throughout the province.

TITLE OF STUDY

A study of the needs of children and youth in the province of Nova Scotia with respect to psychiatric mental health and related services.

OBJECTIVES

1. Identify and describe psychiatric mental health and related services now being provided in Nova Scotia for children/youth including types and location, scope, coverage, resources, funding, etc.

2. Determine from literature searches and other reviews the range of potential services, priorities, etc., presently available for this age group in other areas.

3. Pinpoint gaps, overlaps, etc., which characterize the existing delivery system for children/youth in Nova Scotia.

4. Develop a blueprint of services for the target group throughout the Province including resources required (types and numbers) method of delivering programs, etc.

5. Determine whether further research is required to arrive at the needs of the target group in greater detail e.g., an epidemiologic type survey may be done on a more systematic and detailed basis to arrive at numbers and distribution of children/youth throughout the Province.

PROCEDURES

1. Examine records of hospitals, clinics, etc., and consult with physicians (psychiatrists but also general practitioners and paediatricians, where applicable) and others involved with psychiatric mental health and related programs to learn the nature and extent of services of this type now being provided for children/youth in Nova Scotia.

2. From the foregoing information develop and incorporate into the report a comprehensive description of the range of services presently being provided for the target group in Nova Scotia.

3. Conduct a thorough review of the literature and interview (by correspondence, telephone and personal contact) those people in other areas familiar with psychiatric mental health and related programs for children/youth.

4. From the foregoing information prepare a description of the range of existing services, what services are lacking and what are considered needed and in what priority.

5. Interview key informants in Nova Scotia - those in existing programs (see Item No. 1 above) and involved with community activities that are related to children/youth and their families (where relevant to the study) to learn what they know and perceive concerning gaps in services and needs of the target group.

TIME FRAME

The study would require approximately eighteen months to complete, including time for advance preparation, interviews with agencies, practitioners, and other key informants in several communities in Nova Scotia, review of current literature, analysis of service utilization data, meetings with steering and/or advisory committees in preparation of the report.

Appendix i-3

STAFF

Principal Investigator - There is need for a principal investigator at the Ph.D. level or equivalent status with a background in social science disciplines, with skills and experience in research (preferably in mental health or related fields) particularly in studies of utilization and assessment of unmet needs, epidemiology, health services research or mental health program planning.

SENIOR ADVISOR

Senior Advisor - Would be highly qualified individual with a background similar to that required for principal investigator. However, he/she will have had several years experience in this field and must have a special knowledge and interest in children and youth programs.

GEOGRAPHIC SCOPE OF THE STUDY

The study would involve all parts of Nova Scotia including the Halifax-Dartmouth metropolitan area. Those communities served by mental health clinics in the province could be the focal point for visits and interviews by the principal investigator.

ADVISORY COMMITTEE: MEMBERSHIP AND OPERATION

It is recommended that the advisory committee should consist of representation from the Metropolitan Mental Health Planning Board, Association of Mental Health Staffs of Nova Scotia, Family and Child Welfare Association of Nova Scotia, Provincial Departments of Social Services and Education and that ex-officio members of the committee be the Director of Psychiatric Mental Health Services Division of Nova Scotia, Executive Director of the Metropolitan Mental Health Planning Board, Principal Investigator and Senior Advisor. Additional advisors to the committee have been designated as Dr. A.H. Leighton, Professor, Department of Psychiatry and Preventive Medicine, Dalhousie University and Dr. B.K. Doane, Head and Professor, Department of Psychiatry, Dalhousie University. The committee membership would therefore consist of the following:

Judge L.E. Moir, Chairman
Dr. Gerald Gordon, Liaison with Professional Advisory Committee (Professional Advisory Committee has been designated as the Children's/Adolescent Services Committee of MMHPB)
Dr. D. Archibald, Association of Mental Health Staffs of N.S.
Ms. E. Douma, Association of Mental Health Staffs of N.S.
Mr. A. Arsenault, Association of Mental Health Staffs of N.S.
Mr. T. Townsend, Family and Child Welfare Association of N.S.
Representative, Department of Education
Representative, Department of Social Services
Dr. F.R. Townsend, Ex-officio
Mr. J.P. Martin, Ex-officio
Principal Investigator, Ex-officio
Senior Advisor, Ex-officio

Other than the principal investigator and senior advisor, committee members would serve without stipends (being seconded from their Department or agency) but would be reimbursed for out-of-pocket expenses for travel, meals and accommodation when incurred for attendance at meetings or at other committee authorized sessions. It is envisaged that the committee would meet 6-7 times in Halifax, first to set policy and guidelines for the study, later to review progress with principal investigator and senior advisor and finally to review draft and final versions of report before it is submitted to the Minister of Health.

BUDGET

Budget for this study based on current estimates and allowance for cost increases for the next two years is estimated at $38,500. Details of the budget may be found on attached sheets.

Respectfully submitted,

Judge L.E. Moir
Chairman, Committee Established
to Prepare Terms of Reference
for Province Wide Study of
Children's Services

MINISTER OF HEALTH
NOVA SCOTIA

O. BOX 488
AX. NOVA SCOTIA
B3J 2R8

RECEIVED
JUL 10 1980

JUL 8 1980

Judge L. E. Moir
Board Chairman
Metropolitan Mental Health Planning Board
Garrison Building
6th Floor, 1526 Dresden Row
HALIFAX, Nova Scotia

Dear Judge Moir:

I am replying to your response to my request of January 12th, 1979, for a proposal from your Board to carry out a study of Children's Psychiatric Mental Health Services in the Province of Nova Scotia. My Department has reviewed the proposal and I am pleased to advise that we believe the methodology outlined will provide the Department with the direction required and therefore you are hereby approved to proceed with this study in accordance with the methodology outlined.

At this time funds for the project are somewhat limited, and we would request that you not exceed $20,000 for the 1980-81 fiscal year, and indeed it would be appreciated if you could keep the costs as close to $10,000 as possible. The remaining costs will be provided in the 1981-82 budget.

We anticipate that when the Metropolitan Mental Health Planning Board submits its 1981-82 budget that you will include an estimate of the additional funds that will be required to complete the study.

I want to sincerely thank you for so willingly responding to my request for this study, and I trust that over the years it will prove to be a good investment on behalf of the children of Nova Scotia.

May I also thank you for recently meeting with me and giving me a detailed outline of your activities over the past year, as well as your immediate objectives for the future. Your advice and coordinating efforts are appreciated.

Yours sincerely,

G. Sheehy, D.V.M.

cc: Dr. F. R. Townsend

APPENDIX ii

When different studies come forth with similar recommendations the two efforts must naturally reinforce one another: that is one of the reasons why many of the recommendations of the 1970 One Million Children—the report of the Commission on Learning and Educational Disorders in Children—are included here as appendix ii. The CELDIC study was a very broad, Canada-wide effort and despite the passage of some thirteen years its analyses of needs, problems, and solutions remain, alas, largely current, its recommendations often unfulfilled. That is another reason why it is worth reminding the reader of some of its conclusions by reprinting them here. The focus of One Million Children was considerably broader than that of the present Study, however, while certain of its recommendations do not appear relevant to the present Nova Scotia situation and so have been omitted. The interested reader is referred to the original report for the full set and, perhaps more important, to the hundreds of pages of discussion upon which they were based.

Appendix ii-2

ORGANIZATION OF SERVICES

Local Services

Policy and Planning

that comprehensive community personal care services be established in each local community to serve population units of between 25,000 and 50,000 persons. (from page 476)

that for each area or locality with a population of 25,000-50,000 there be set up a community services board to promote and plan the establishment development and maintenance of a comprehensive and coordinated network of personal care services. (from page 476)

that local services be given the greatest possible degree of administrative responsibility in their operation consistent with standards of care established and supervised by provincial authorities. (from page 476)

that local authorities determine service priorities as dictated by local needs and that consistent with government legislation and policies these be linked to authority to determine allocation of funds made available to the local community for services. (from page 476)

that local need be the primary determinant in developing local services rather than the funding provision of federal and provincial governments. (from page 476)

that the development of neighbourhood councils representative of consumers of service voluntary agencies and helping professions be encouraged in local communities to assist the community services board and the community services centre. (from page 476)

that the different agencies in a community improve understanding and coordination by cross-appointments to their boards of directors. (from page 477)

that school buildings be designed and utilized as the focus for neighbourhood activities. (from page 477)

Coordination of Services

that to coordinate the delivery of services a community services centre be established for areas with a population of 25,000-50,000. (from page 477)

Appendix ii-3

that community based and residential facilities be components of the same network of local services with easy access from one to the other. (from page 477)

that in provincial and local planning for health care those services designed to promote and maintain physical health and mental health be integrated. (from page 477)

that in the planning and development of health services and in the education of health personnel there be an integration of the principles and methods of preventive and therapeutic medicine. (from page 477)

that services provided by health be coordinated with the services and programs provided through education, welfare and corrections. (from page 477)

that different services be encouraged to share the same building in order to increase communication and consultation between their personnel. (from page 477)

that in order to maintain the continuity of service in group homes, hospitals or other settings the child in residence have continuing contact with the professional staff of his local community agency. (from page 477)

that cumulative records kept in each community service be indexed centrally in the local community and coordinated with the records division of the provincial government. (from page 478)

that health authorities provide for the collection and indexing of pertinent information regarding the pre-school child which with appropriate safeguards regarding confidentiality can be made available to those who require this information to plan to meet the continuing needs of the child. (from page 478)

that school records be maintained and be integrated with records of other community services in a community services index. (from page 478)

Services in a Local Community

that in each local community there be established comprehensive family counselling, family service, child welfare, and protection programs. (from page 478)

that in each local community there be established a publicly financed homemaker service on a comprehensive basis to support and sustain children in their own homes. (from page 478)

that in each local community there be established group homes to provide an alternative to institutional or hospital care for any child who would benefit from this service. (from page 478) that high priority be given to the development of day school programs and active steps be taken to initiate group homes for children presently in student residences and residential schools in order to minimize their isolation from community life. (from page 478)

that for the diagnosis and treatment of mental retardation and emotional and learning disorders in children health authorities provide outpatient clinics, inpatient, hospital or residential care and day treatment services. (from page 478)

that the quantity, quality and accessibility of prenatal and maternity services be improved to permit the early detection of high risk situations that might result in mental retardation or neurological disorders in the newborn child. (from page 478)

that postnatal care include an assessment of the child's emotional status and learning abilities and that appropriate training be provided for doctors and nurses to make this possible. (from page 479)

that genetic counselling be available to the parents or relatives of a child whose abnormal condition has recognized genetic components. (from page 479)

that educational authorities make nursery and kindergarten programs available to all children who are likely to benefit from these preschool experiences and that in the development of these services priority be given to children who are physically, educationally or socially handicapped. (from page 479)

that communities give priority to the development of a variety of day care programs for infants, preschool and school age children. (from page 479)

that space and staff be provided for day care programs in all housing areas and schools where need for this service is revealed and in places where large numbers of mothers are employed. (from page 479)

Operation of Services for Children with Special Needs

that curricula contain programs designed to meet the needs of children with emotional and learning disorders. (from page 480)

that as an urgent priority educational authorities develop a variety of educational opportunities including vocational and work-study programs appropriate to the needs of the adolescent with emotional or learning disorders. (from page 480)

that school boards, settlement houses and community groups develop and promote programs to broaden the experience of children from socially and economically disadvantaged areas. (from page 480) that health authorities direct special attention to the health needs of children in economically disadvantaged areas and experiment with flexible patterns in the delivery of health care to children in settings close to the child's home such as schools and day care centres. (from page 481)

that health and welfare programs include the provision of adequate nutrition especially for children living in low-income neighbourhoods. (from page 481)

that all juvenile courts use specialists in child and adolescent behaviour to assist in the diagnosis of the problems and needs of the young offender and to formulate rehabilitation programs. (from page 481)

that aftercare services for delinquents be given budget priority to increase the number of staff involved in this function and to improve their training. (from page 481)

that juvenile courts and training schools encourage the participation of individuals and community groups in the planning and operation of existing programs to increase the community understanding and support for the needs of the juvenile delinquent. (from page 481)

that health services and especially mental health services be flexibly organized to provide crisis intervention and access to service for children and adolescents in emergency situations such as suicide attempts and drug reactions. (from page 481)

that admission to a special school hospital unit or child care institution take place only following the development by community services of a treatment plan based upon a medical and psychological examination and, as appropriate, an educational assessment. (from page 481)

that an assessment of the child's differing educational and treatment needs be provided so that remedial education resources can be mobilized in the residential centre or within its local school system and that appropriate funding mechanisms be developed so that school systems in close proximity to residential centres are adequately compensated for the extra demands upon their staff and facilities. (from page 481)

that guardianship responsibility be designated to a responsible individual or agency outside the residential centre in those instances where a child is not in the care of his own parents and that this person or agency be required to participate in a periodic review of the treatment planned for the child. (from page 482)

Coordination and Support of Personnel

that persons who are responsible for the day to day care of the child with emotional and learning disorders be provided with support and assistance from specialist consultants. (from page 482) that to assist him to work more effectively with children with emotional and learning disorders the classroom teacher have direct access to consultants both from within the school system and from community services. (from page 482)

that a department be established within the school to provide educational assessment services and to coordinate the supportive services provided to the classroom teacher. (from page 482)

that the front line position and function of the family physician and public health nurse be recognized and appropriate consultation and supportive community services be developed to enhance their role in the prevention detection and treatment of emotional and learning problems in children. (from page 482)

that health personnel with special training in mental health and in the diagnosis and treatment of emotional and learning disorders in children provide consultation to family physicians, public health nurses and the staffs of schools and community agencies to increase their skill in working with children. (from page 482)

that child welfare agencies develop procedures and maintain liaison with the staff of other community services and provide consultation to improve the identification and management of situations where there is danger of child neglect or abuse. (from page 483)

that the personnel working with the young offender have access to a variety of community, education, health and welfare services. (from page 483)

that with parent or client consent and the safeguarding of confidentiality central records be made accessible to the professional personnel working with the child. (from page 483)

Regional Services

that regional groupings take place for the provision and maintenance of specialized services and facilities and that these be developed by joint planning between community services boards. (from page 483)

that specialized regional services and facilities be responsible to and be funded through local community services boards. (from page 483)

Appendix ii-7

Federal and Provincial Roles in Organization of Services

Provincial Roles

that provincial governments in cooperation with private agencies work progressively towards the establishment of a comprehensive integrated network of services fully accessible to all children in their home communities.
(from page 484)

that each provincial government establish a cabinet committee with a designated chairman responsible for the coordination of personal care services.
(from page 485)

that provincial governments establish general policies for the provision of personal care service programs by local communities and enact legislation and establish regulations to set and enforce standards of care and to provide and supervise the expenditure of funds so that these are maintained.

that the geographic boundaries of the education, health, welfare, corrections, and manpower components of the network of service programs be the same.
(from page 485)

Standards and Funding

that in establishing standards and funding policies for family services and child welfare services provincial governments give high priority to integrating these two functions. (from page 485)

that health authorities cooperate with education and welfare authorities in the development of standards for licensing of public and private day care centres and nursery schools and that such standards include reference to personnel qualifications and appropriate programs and that periodic inspection to ensure the maintenance of standards be mandatory. (from page 485)

that a provincial cabinet minister be clearly responsible and accountable for the development and enforcement of standards for child protection programs and for the care provided for children who are wards. (from page 485)

that the civil rights of children and their families in child protection proceedings be adequately safeguarded through the provision of legal representation before the courts including the right of review and appeal of wardship decisions. (from page 485)

that provincial governments provide funding and set standards for the establishment in local communities of a range of placement choices including group homes to improve continuity of care to children growing up as wards.
(from page 486)

that provincial governments revise the present systems of funding and administration of residential care to facilitate the use of all modes of treatment to meet the needs of emotionally disturbed children and their families. (from page 486)

that provincial government grants to residential programs be contingent on the maintenance of standards and that this be ensured by a regular review of the program. (from page 486)

that provincial governments provide funds to develop inpatient services geared to crisis intervention for children with emotional disorders. (from page 486)

that to license professional personnel provincial governments establish licensing bodies composed of representatives of the professions, the consumers of service and the government. (from page 486)

PERSONNEL

Policy and Planning

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that national and provincial manpower planning committees be established to coordinate planning for recruitment and training for the personal care services field. (from page 488)

that a recruitment program and a system of bursaries be developed to increase the personnel available for work with children with emotional and learning disorders. (from page 488)

that governments in cooperation with training institutions and employing agencies promote the development and expansion of training opportunities in the personal care services field through in-service training, retraining and new training programs and that financial resources to make these possible be provided. (from page 488)

that registers be developed provincially to contain data about the educational qualifications and deployment of personnel in the fields of education health welfare and corrections with priority given to personnel qualified to work with children with emotional and learning disorders. (from page 488)

that provincial governments prepare materials to stimulate recruitment and cooperate in the development of training opportunities for careers in child care, day care and health related services that work with children with emotional and learning disorders. (from page 488)

that governments offer economic and other incentives to encourage health services personnel to accept employment in regions of the country that are inadequately served. (from page 488) that in all personal service programs increased use be made in administrative positions of personnel trained in administration. (from page 488)

that the present practice of promoting highly trained and experienced professional personnel into administrative positions be actively discouraged. (from page 489)

that if persons from the helping professions choose to transfer to an administrative role they be trained in administration and their remuneration be based on their administrative skills and responsibilities. (from page 489)

that professionals in their primary professional roles be remunerated on the basis of education skills and experience rather than on their position in an organizational hierarchy. (from page 489)

that agencies serving children with emotional and learning disorders expand their programs for volunteers of all ages. (from page 489)

that programs for youth volunteers to work with children with emotional and learning disorders be developed. (from page 489)

Training of Personnel

Education Institutions

that institutions training personnel to work with children develop a curriculum designed to provide the student with an understanding of the normal child and his world as a prerequisite to the more specialized understanding of the child as student, patient, ward and offender. (from page 489)

that educational institutions develop interdisciplinary and inter-professional seminars and learning experiences for students preparing to work with children. (from page 489)

that teacher training institutions redesign their curricula to include courses and practical experiences to increase the teacher's understanding of
individual differences
the affective life of the child
the meaning of the major social institutions—family, school, community—in the life of the child
the characteristics, causes and treatment of emotional and learning disorders, group processes and the role of the teacher as a person in the group. (from page 489)

that teacher training institutions and school systems experiment and develop improved methods of providing practical experiences for teachers in training. (from page 490) that teacher training institutions design inter-disciplinary educational experiences that will assist the teacher to fulfill his professional role in partnership with other helping services in the community. (from page 490)

that universities and professional schools in partnership with field settings develop interdisciplinary training programs for the professions to assist them to increase their capacity to serve as consultants. (from page 490)

that educational institutions providing training for the helping professions place emphasis on techniques of interviewing and on communication with parents. (from page 490)

that emphasis be placed on the importance of crisis intervention in the training programs for the personnel in the personal care services. (from page 490)

that educational institutions include as a part of the curriculum of doctors, nurses and other health personnel theoretical and practical training in the developmental disorders of childhood and adolescence. (from page 490)

that professional schools training personnel for work with children and adolescents or for the administration of justice include juvenile delinquency in their curriculum. (from page 490)

that the recruitment training and deployment of staff of residential centres be considered in overall planning to meet the needs of emotionally disturbed children. (from page 490)

that the training of residential staff at all levels and in all disciplines include practical experience in community based service programs. (from page 490)

that training institutions recognize the need of citizens groups for staff consultation and service and that time and faculty resources be devoted to the study of social change processes with a view to improving the preparation of staff for these new roles. (from page 491)

that educational institutions, professional associations and employing agencies cooperate to establish for the welfare related training courses a clear statement of relationship between different training programs in this field and the access and entry requirements for advancement from one program to another and job descriptions of the functions or services to be performed that are appropriate to content and duration of the training programs. (from page 491)

In-service Training

that welfare and child welfare agencies establish in-service training programs which are recognized as a basis for promotion. (from page 491) that health authorities provide opportunities for refresher and in-service training programs in the developmental disorders of early childhood for family physicians and public health nurses involved in prenatal, maternity and postnatal care. (from page 491)

that in-service and advanced educational experiences be made available to all personnel associated with the school system. (from page 491)

that orientation and support be provided for volunteers appropriate to the role they are to fulfill with children with emotional and learning disorders. (fom page 491)

Professional Roles and Responsibilities

that in education, health, welfare and corrections services the professional staff shall have responsibility for
decisions regarding professional care
representation to boards of management of the needs of clients
disciplining its members
providing opportunities for continued professional training. (from page 491)

that the professions provide leadership in solving the manpower crisis by participating in the development of training programs and by teaching supervising and supporting others to work with children with emotional and learning disorders. (from page 492)

that professionals working as a team respect the principle of participation in the decision-making process. (from page 492)

Citizen's Roles and Voluntary Associations

that voluntary associations abandon protective attitudes and cooperate with each other in the development of plans and programs for children with emotional and learning disorders. (from page 492)

that voluntary agencies cooperate with government to negotiate a transfer to public auspices and public funding of those services that have proven successful on a demonstration or pilot project basis. (from page 492)

that voluntary associations resort more extensively to an agitating role in relation to the public and government in demanding general availability of services for children with emotional and learning disorders. (from page 492) that voluntary organizations take active and immediate steps to increase the representation from low income groups from users of services and from youth on their boards of directors and policy making committees. (from page 492)

that voluntary organizations combine to set up a central index and data processing system in order to make specialized information available to other agencies and associations and citizens who are interested in social problems and particularly in children with emotional and learning disorders. (from page 492)

RESEARCH

that the Government of Canada provide financial assistance to research programs on emotional and learning disorders in children. (from page 493)

that provincial governments establish research programs on emotional and learning disorders in children in order that all personal care services and programs are subject to periodic evaluation of their effectiveness and to stimulate and fund pilot projects to improve the services available to children with emotional and learning disorders. (from page 493)

that educational authorities assume responsibility for experimentation with new methods and for evaluation and action research to improve educational programs for children with emotional and learning disorders. (from page 493)

that research consultants in education, health, welfare and corrections be encouraged to provide leadership and assistance in evaluation and research projects in the agencies serving children with emotional and learning disorders. (from page 493)

that governments encourage and support demonstration projects and research into methods of minimizing the problems associated with the processes of migration and immigration especially for children and youth. (from page 493)

that teacher training institutions encourage and train personnel to engage in research and evaluation of educational programs. (from page 493) iii

APPENDIX iii

METHODOLOGY, SOCIAL INDICATORS, AND THE ASSESSMENT OF NEEDS

At the Study's inception, assessing children's and adolescents' needs for mental health and related services in each part of Nova Scotia appeared essential. Three different approaches to needs assessment were explored.

The most accurate, demanding and expensive of these was the psychiatric epidemiological survey. In this type of research, a population is sampled and the actual overall prevalence and yearly incidence of specific disorders is determined. Chapter VII recommends that such research be undertaken in the future but the present Study was not in a position to do so. Two other approaches were, however, utilized, though to a limited extent.

One of these was the key informant method, a sociological adaptation of an anthropological technique. The anthropologist, in studying a community, looks for particularly knowledgeable and communicative individuals. It is to these local experts that he or she puts the many hundreds of questions whose answers, pieced together, describe the way of life of a people (that is, comprise an ethnography). Sociologists, in assessing needs, use as their "key informants" professionals believed to be knowledgeable in a particular area. In the case of this Study, that area was of course children's/adolescents' mental health and related services.

Since this Study's Principal Investigator happened to be an anthropologist, the key informant approach was congenial. The key informants interviewed were the staffs of Nova Scotia's mental health and child welfare agencies and allied educators and members of the "helping professions" in general. But because the Study was to be broader than a simple assessment of needs, interviews were conducted with a very wide range of people—police, family court judges, clergy, family practitioners, pediatricians, members of voluntary organizations (such as Big Brothers/Big Sisters), teachers and guidance counsellors: and parents and children. In addition, in order to ensure that all who wished to have input into the Study could do so, advertised public meetings were held in:

Kentville
Bridgewater
Sydney
New Glasgow
Yarmouth
Sackville
Halifax
Dartmouth

As the Study progressed, it gradually became clear that the key informants were saying little not already included in previous studies. The massive report, One Million Children, published in 1970 by the Commission on Learning Disabilities and Emotional Disorders in Children and covering all of Canada, had already made virtually all the points key informants and others in Nova Scotia were making. Other studies, too, told the same story. The problem became not so much one of identifying needs as of understanding why difficulties in delivery services to young people persisted and recurred despite past studies and their thoughtful recommendations.

The focus of the Study shifted accordingly. Interviews with key informants and with many others continued but the goal of the Study became one of designing ways to set in motion processes which could deal with recurring problems (such as the setting of priorities among competing needs, or ending competition among age groups for services). Some assessment of needs by key informant interview did take place, however, and the resulting recommendations are included in the body of this report and, by way of emphasis, in an edited version of the recommendations of One Million Children (appendix ii).

However, key informants, as Warheit, Buhl and Bell (1978) point out, almost invariably claim that greatly increased services are vital for a region, so that sole reliance on key informants makes it impossible to differentiate among regions in assessing need for services. These authors argue that social indicators avoid this problem while providing objective, quantifiable data on what services are actually required in a given locality. Social indicators were therefore included in the early stages of this Study, before it became clear that they would not, at this time, be particularly useful for planning children's and adolescents' mental health services in Nova Scotia. (After all, in the near total absence of services for young people in much of the Province, it hardly requires a social indicator to demonstrate that a minimum level of service is needed.)

A social indicator (or "socio-demographic indicator") is a demographic datum, usually an item from a census, used to predict the prevalence of a particular type of problem (e.g., mental illness) and therefore of the need for services. In the U.S.A., an elaborate system of mental health social indicators has been developed, the Mental Health Demographic Profile System (MHDPS) of the National Institute of Mental Health (Rosen, Goldsmith and Redict 1979). Social indicators specifically for the mental health of children and adolescents do not appear to exist (though there is no reason they could not be developed). However, since the mental health of the child is presumably closely related to that of his or her family, it may be that what Pollack (1975:282) refers to as "family indices of mental health" would be predictors of child/adolescent mental health. Though Pollack's measures were not used in the present Study, future researchers may wish to do so.

By coincidence, at the same time this Study was being initiated a Dalhousie University student in Physical Education, Ms. Carol Boutelier, was completing a Master's thesis (1981) dealing with need and utilization of mental health services in Nova Scotia. A research assistant with the Study, Ms. Dianne Young, was asked to select among Ms. Boutlelier's social indicators those which seemed most appropriate for this Study. Ms. Young ranked Nova Scotia's counties in terms of each of a number of indicators, then calculated a composite (and unweighted) overall rank. Table 43 is based on the result. These results are, however, very preliminary and they are included only as an aid of future researchers.

BLE 43: RANKING OF COUNTIES ACCORDING TO SIX SOCIAL INDICATORS AND EACH COUNTY'S PER THOUSAND 0-19 POPULATION *

unties	Families headed by Lone Parents Between 15-35 years** (1976 Census)	Less than Grade Five Education*** (1976 Census)	University Education**** (1976 Census)	Average individual Income⁺ (1971 Census)	Percentage of Unemployed Men & Women in the Labour Force⁺⁺ (1976 Census)	Mean	Re-Rank By Mean	1981 Utilization Rank⁺⁺⁺
napolis	15	17	11	7	17.5	13.5	16	7.5
tigonish	14	14	18	17	10.5	14.7	18	10
pe Breton	4	10	12	16	1	8.6	8	17
lchester	5	16	13	14	17.5	13.1	14.5	12.5
mberland	3	11	6	6	5	6.2	5	10
gby	9	3	9	1	7	5.8	3	16
ysborough	10	2	1	2	3	3.6	1	4
lifax	1	18	17	18	14	13.6	17	2.5
nts	8	12	5	11	12.5	9.7	9	14
verness	18	6	15	12	6	11.4	13	15
ngs	11	13	16	15	10.5	13.1	14.5	1
nenburg	16	7	7	8	15	10.6	12	2.5
ctou	6	15	10	13	8	10.4	11	7.5
eens	17	4	3	9	16	9.8	10	6
chmond	12	1	4	10	2	5.8	3	9
elburne	7	9	2	4	12.5	6.9	6	12.5
ctoria	13	8	14	3	4	8.4	7	18
rmouth	2	5	8	5	9	5.8	3	5

* The lower the rank the greater the indicated need for services. For all counties each social indicator was expressed in terms of percentage of the national average, so that for all variables Canada = 100 percent. Based on these percentages the counties were ranked in two ways depending on the variable being measured. For "positive" variables which indicate a possible need for mental health services, counties were ranked from the highest to the lowest percentage. These positive social indicators include Lone Parent Families, Less Than Grade 5 Education, Percentage of Unemployed Men and Women in the Labour Force and Percentage of the County Population that are 0-19 years. The other two variables, University Education and Average Individual Income, may be considered negative social indicators, e.g., there is less need for mental health services among those with high incomes and university education. Therefore, for these two social indicators counties were ranked in reverse order, from the lowest to the highest percentage.

** According to Statistics Canada a "Lone Parent Family" is one which has a never married child 0-24 years living at home. The variable "Families headed by Lone Parents between 15-35 years" was used in an effort to exclude Lone Par Parent Families with post-adolescent children. The Lone Parent Families (LPF) ranks differed somewhat from their "Families headed by Lone Parents between 15-35 years (LPF 15-35)" equivalents. Some of the most significant changes include: Victoria ranking 1 for LPF and 13 for LPF 15-35; Inverness ranking 3 for LPF and 18 for LPF 15-35; Guysborough ranking 5 for LPF and 10 for LPF 15-35; Antigonish ranking 9 for LPF and 14 for LPF 15-35; Richmond ranking 6 for LPF and 12 for LPF 15-35; Yarmouth ranking 11 for LPF and 2 for LPF 15-35; Colchester ranking 12 for LPF and 5 for LPF 15-35; Hants ranking 13 for LPF and 8 for LPF 15-35 and Shelburne ranking 14 for LPF and 7 for LPF 15-35.

*** The population used by Statistics Canada for calculating the Level of Schooling is all persons 15 years and over. Therefore, for both educational variables, "Less than Grade 5 Education" and "University Education", the population counted includes adolescents presently attending school or university.

**** The variable "University Education" includes persons who have attended or are attending university and who may or may not have received a certificate, diploma or degree.

+ The 1971 census provides the most recent data for "Individual Average Income" by county. However it is possible to obtain information about average individual income reported on Income Tax Returns for 1979. These data naturally exclude individuals not filing a return. The relative rank of counties alters depending on whether one is comparing the 1971 "Average Individual Income" (AII) or the 1979 "Average Individual Income calculated from Tax Returns" (AII-TR). These changes include Cape Breton ranking 16 for AII and 4 for AII-TR; Colchester ranking 14 for AII and 7 for AII-TR; Richmond ranking 10 for AII and 6 for AII-TR; Queens ranking 9 for AII and 16 for AII-TR; Lunenburg ranking 8 for AII and 18 for AII-TR; Cumberland ranking 6 for AII and 2 for AII-TR; Yarmouth ranking 5 for AII and 9 for AII-TR; and Shelburne ranking 4 for AII and 11 for AII-TR. It was felt that the census data provided more valid, if older, information.

++ Three pairs of counties had equal percentages of unemployed males and females within the labour force. In order to break the ties the average ranking was given to both counties. The counties affected by this were Antigonish and Kings, both having 9.2% of their labour force unemployed, Hants and Shelburne with 7.8% each and Annapolis and Colchester with 6.8% unemployed.

+++ The counties were ranked according to their utilization rate of outpatient facilities per one thousand 0-19 age population, for 1981. These data are to be found in table 4 of Chapter IV. The lower the rank the higher the utilization rate.

It is interesting to note, however, that high need for mental health services for a given county (as indicated by low average rank) appears to have no relationship whatsoever with high (1981) utilization rate. Thus, if there is any validity to all to the social indicators, and if the fact that various indices come from different years does not invalidate this exercise, then degree of need for mental health services among young people has no relationship to amount of utilization, in Nova Scotia.

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POOR

QUALITY

ORIGINAL